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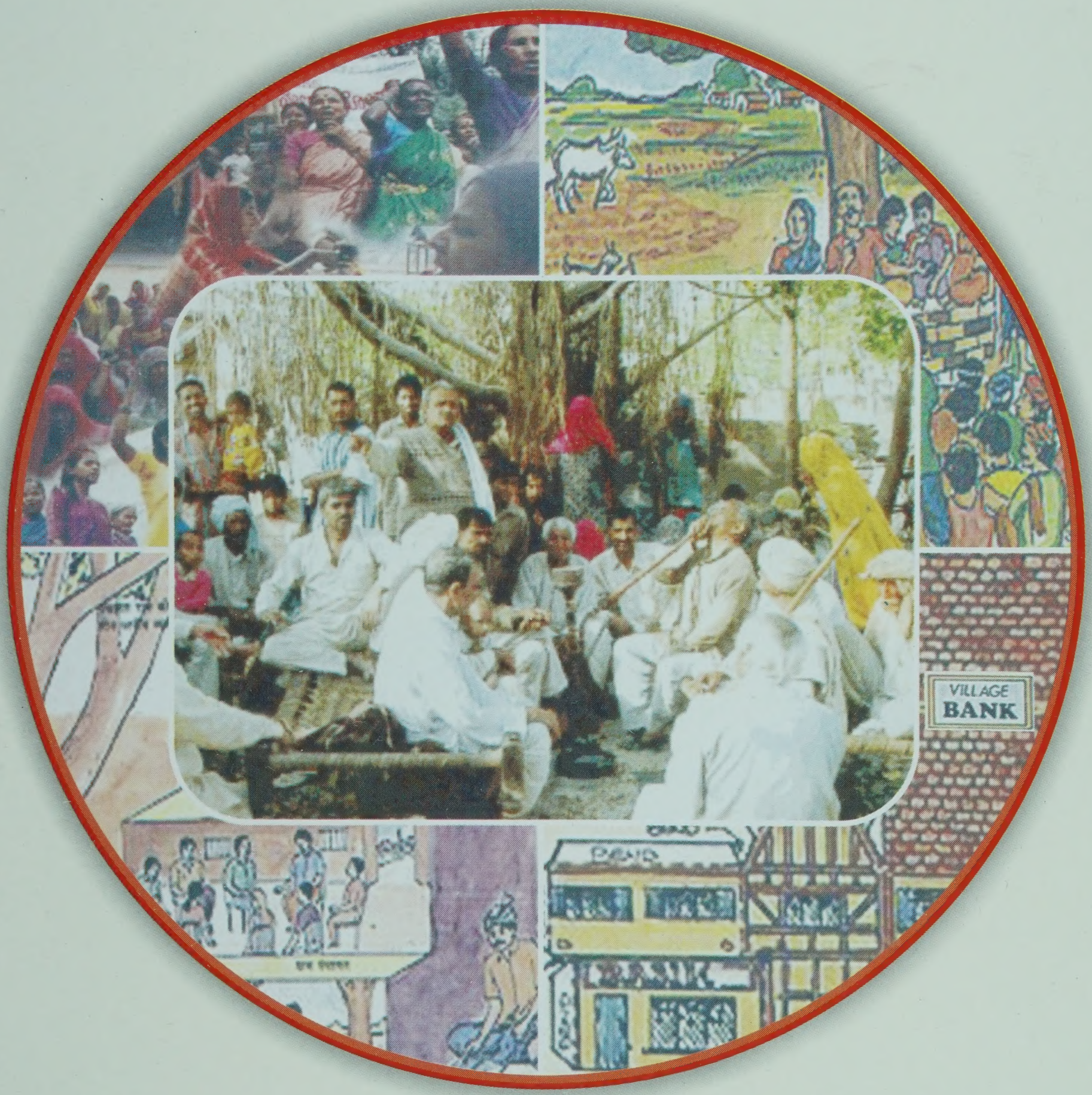
REPORT OF THE WORKING GROUP
ON
ROLE OF PANCHAYATI RAJ INSTITUTIONS &
SELF HELP GROUPS IN POPULATION STABILIZATIO



राष्ट्रीय जनसंख्या आयोग

National Commission on Population

Government of India

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GOVERNMENT OF INDIA
NATIONAL COMMISSION ON POPULATION
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Member Secretary

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FOREWORD

Demographic stabilization is an integral part of the developmental process itself and the National Population Policy (NPP) 2000 has put a great deal of emphasis on the role of Panchayati Raj Institutions (PRIs) and Self-Help Groups (SHGs) in formulating and implementing area specific policies and programmes relevant for population stabilization. Since at present the NPP goal of ensuring the delivery of integrated package of essential services at the village and household level still remains unrealized it is necessary that more emphasis should be paid to the demographic decentralization through devolution of responsibilities and resources to the Panchayats. Apart from convergence of many ongoing programmes more coordination is required with regard to the work presently being done by multiple agencies and employees representing different government departments who are working in the rural areas. In conformity with the spirit of 73rd Constitutional Amendment most of the field level functionaries should be brought under the control and supervision of the democratically elected Panchayats. This is essential to improve accountability and promote transparency in their functioning.

The mobilization and involvement of women through SHGs can greatly help solve many social problems. Issues of vital concern for society in general and women in particular such as mother and child health, nutrition, literacy, family planning, thrift and hygiene can be effectively promoted by WSHGs.

In view of the above, the NCP constituted a Working Group on " The Role of Panchayati Raj Institutions and Self-Help Groups in Relation to Population Stabilisation ". After examining the various issues relating to the role of PRIs and SHGs in population stabilization, several recommendations have been made on capacity building of Panchayats, future directions for PRIs and the strategic steps that may require to be taken for achieving the objective of population stabilization in the country.

I would like to thank the Chairman and Convener along with the distinguished Members of the Working Group for their efforts in finalizing the report. The report of the Working Group is being published for wider circulation of its recommendations.

K Singh

(Krishna Singh)
Member Secretary

CHAPTER I

Introduction

The imperative of a stable population in the context of resource endowments of this country and the level of its economic growth has been recognized right since Independence. Over the years, there have been changes in our approach to controlling the growth of population. Multifaceted nature of population problem has come to be increasingly appreciated and the strategy to deal with it has taken note of the dimensions that would have to be integrated in developing a suitable approach for population stabilization. Despite the initiatives of the government and civil society, country's population has increased by three times in 2001 compared to what it was in 1951.

In realization and recognition of the fact that greater efforts were needed to control the growing population, National Population Policy (NPP) was announced in 2000 by the Government. The NPP 2000 is an attempt to evolve a strategy to meet the "unmet needs for contraceptives, health infrastructure and health personnel and to provide integrated service delivery for reproductive and child health care". The medium term objective of the NPP is to bring total fertility rate (TFR) to replacement levels by 2010 and achieve a stable population by 2045. Various sectoral programmes have been sought to be woven in a common strand to achieve the goals set by NPP. Effective implementation of programmes with emphasis on convergence of sectoral programmes at the ground level is the hallmark of the NPP strategy on population stabilization.

The National Population Policy also envisaged setting up of new

structures, the most prominent being constitution of a national population commission presided over by the honorable Prime Minister to oversee and review the implementation of National Population Policy and similar commissions at the State level. Accordingly, National Commission on Population was set up on 11th May 2000 – the day India reached one-billion population mark. The Commission has members from a very wide cross section of society. The objectives which the Commission shall pursue are primarily focused on promoting synergy between demographic, educational, environmental and developmental programmes so as to hasten population stabilization, to promote inter-sectoral cooperation in planning and implementation across government agencies and to involve civil society and the private sector to facilitate the development of a vigorous people's movement. In the very first meeting of the Commission held in July-August 2001, some members advocated that Panchayats should be made the focal point of the programme in order that it becomes a people's movement. Mention was made about the need for involvement of 10 lakh women Panchayati Raj members in a major way and for empowering Panchayats to play a crucial role. Separately, prominent industrialist, Shri Ratan Tata suggested that each Gram Panchayat should prepare a paper on social and demographic charter with focus on population, reproductive and child health covering, among others, nutrition and hygiene. The women Panchayats Sarpanchs should get a key role in the process. NCP in its meeting held on 22nd July 2000 decided to set up working groups on different themes relevant to the goal of achieving population stabilization. One of them was exclusively devoted to the role of PRIs.

The Working Group on the role of Panchayati Raj Institutions and Self-Help Groups in Population Stabilization was constituted vide Order No.N-11011/25/2000-NCP dated 9th October, 2000. The Working Group was headed by Shri K B Saxena, the then Pr. Adviser, Planning

Commission. Non-Governmental Organizations (NGOs), State Institutes of Rural Development, representatives of Central Ministries and State Governments, were represented on the Working Group. The Group also benefited in its deliberations from the Members who were co-opted. The Group was expected to identify gaps and suggest alternative strategies that would leverage the establishment of a third tier of government in the form of Panchayati Raj Institutions (PRIs) to fulfill the objectives of the NPP. The composition and terms of reference of the Working Group are at **Annexure I.**

The Working Group met thrice and held extensive discussions on various facets of the role of PRIs in population stabilization. The meetings were held on 13th November 2000 and 3rd April and 17th August, 2001. Shri P.M. Tripathi, President , AVARD, Prof. N. Ramakantan, Associate Professor, Kerala Institute of Local Administration, Thrissur, and Shri R. C. Panda, Secretary to Government of Tamil Nadu also contributed papers on role of Panchayati Raj Institutions in population stabilization. Notes and views were received from State Institute of Rural Development, Kalayani, and Department of Family Welfare, Government of India. The Report prepared on the basis of discussions and material furnished by the participants and inputs from other quarters was circulated to members of the Committee for obtaining their comments. The changes suggested by some members were incorporated in the revised report which is now being presented.

Chapter I gives the background for setting up of National Population Commission and the Working Group on Role of Panchayai Raj institutions in population stabilization. Chapter II looks at the linkages between population and development which have a major bearing on population problem. Chapter III examines some of the unmet needs

that contribute to growing population. Chapter IV discusses the role of decentralized governance in population stabilization. Chapter V details the immediate steps that need to be taken to stabilize population and role of PRIs in this endeavour. Chapter VI discusses the process of planning at the Panchayat level and need for training and capacity building of PRIs to realise the objectives of the National Population Policy. Role of Self-Help Groups and other Non-Governmental Organizations is analysed in Chapter VII in the context of their role in strengthening PRIs to play their assigned role. Chapter VIII has sought to conceptualise planning process for population stabilization as a strategy of empowerment for PRIs to suggest the future course of direction. The Tenth Plan assigns a catalytic role to National Commission on Population for generating a vigorous peoples' movement to achieve goals set out in National Population Policy-2000. Chapter IX therefore makes specific recommendations which the Commission can initiate to trigger the process of invigouration of PRIs.

CHAPTER II

Population and Development

Population and development are integrally linked. A stable population helps in promoting sustainable development, which in turn improves the quality of life of the people. Equitable distribution of development benefits across various segments of population creates objective conditions and stakes for people to seek and accept small family norm. Thus, any policy for promoting stabilization of population has to be necessarily positioned within the framework of an equitable growth and development strategy. This implies extension of basic amenities to people such as health, education, safe drinking water, housing besides creating employment opportunities and skill development for income generation and upward mobility.

The demographic scenario in India has undergone a significant change in the course of the last century. On 11th May 2000 population of India crossed the one billion (100 crore) mark. The growth process of population during the preceding decade and anticipated increase by the end of the current decade on the basis of current trends may be judged from the following figures.

Table 2.1
Population Growth (millions) 1991–2002

Year	If current trends continue		If TFR 2.1 is achieved by 2010	
	Total Population	Increase in Population	Total Population	Increase in Population
1991	846.3	-	846.3	-
1996	934.2	17.6	934.2	17.6
1997	949.9	15.7	949.0	14.8
2000	996.9	15.7	991.0	14.0
2002	1027.6	15.4	1013.0	11.0
2010	1162	16.8	1107.0	11.75

Source: National Population Policy 2000

During the last hundred years the population of India increased nearly four times from 238 million (24 crore) in 1901 to 1027 million (102 crore) in 2001. While the population of the country grew by one and half times in the first half of the previous century, it showed nearly three times increase in the second half. Today India has to support 16.7 per cent of the world population. India's current annual increase in population of 15.5 million is large enough to create excessive pressures on the resource endowment, environment and the capability of political and economic system to deliver equitable development.

This, however, does not imply that nothing substantial has been achieved on the demographic front. During half a century of implementing national family welfare programme, we have:

- Reduced crude birth rate (CBR) from 40.8 (1951) to 26.4 (1998, SRS);
- Halved the infant mortality rate (IMR) from 146 per 1000 live births (1951) to 72 per 1000 live births (1998, SRS);
- Quadruped the couple protection rate (CPR) from 10.4 per cent (1971) to 44 per cent (1999);
- Reduced crude death rate (CDR) from 25 (1951) to 9.0 (1998, SRS);
- Added 25 years to life expectancy from 37 years to 62 years;
- Achieved nearly universal awareness of the need for and methods of family planning, and
- Reduced total fertility rate from 6.0 (1951) to 3.3 (1997, SRS).

As per the projections made in the National Population Policy, India's population is going to be around 1263.5 million by March 2016.

Population Projections for India (million)

March 1991	March 2001	March 2011	March 2016
846.3	1012.4	1178.9	1263.5

Source: National Population Policy 2000

The imperative of a stable population in the context of the resource endowment of the country, the level of its economic growth and the need for equitable development has been recognized right since independence. The First Five-year Plan (1951-56) itself stated:

"The recent increase in population of India and the pressure exercised on the limited resources of the country have brought to the forefront the

urgency of the problem of family planning and population control. It is, therefore, apparent that population control can be achieved only by the reduction of the birth rate to the extent necessary to stablise the population at levels consistent with requirements of national economy. This can be secured only by the realization of the need for family limitation on a wide scale by the people."

India thus emerged as a pioneer in the field of population policy in 1951 and a 'major effort at social engineering in a democratic polity with an unusually high level of heterogeneity' was initiated. Population policy has since become an integral part of socio-economic development. As a corollary, family planning services and counselling were provided to those who sought them for spacing children or limiting families.

The second Five Year Plan was bolder. It stressed that an effective curb on population growth was an important condition for improvement in income and level of living. Family planning was included as one of the five specific objectives for raising the standard of health of the people. Government of India offered 100 per cent central assistance for providing free sterilization all over the country and for creating basic infrastructure of services relating to family planning.

In the Third Five-Year Plan a more comprehensive thrust was given to the programme as stress was laid on social measures like education, particularly of women, employment, rural water supply while expanding the reach of family planning programmes. This was done in the backdrop of census report of 1961, which showed a rise of 22 per cent in population over the 1951 census figure, and an average rate of population growth of 2 per cent. It was also decided that the annual birth rate should be reduced to 25 per thousand people during the next 10 years. It emphasised

that family planning should be interwoven with constructive activities such as community development and integrated with general medical and health services both in government and non-government sector. Family Planning programme incorporated within its ambit sex and family planning education. During this plan period, greater stress was also laid on the extension approach over the clinic-based approach thus focusing on contact of the targetted couples by the health workers. These initiatives were accompanied by expansion of infrastructure of Family Planning services. It would thus be evident that foundations of population stablisation were firmly rooted in development strategy during this period.

During the Fourth Five Year Plan (1969-71), it was decided to accelerate the pace of the programme by setting up targets for sterlisation and use of contraceptives and to widen the acceptance of oral and conventional contraceptives. Maternal and child services were integrated with the programme as a strategy to increase their acceptability. This was the period when the programme of immunization of infants and pre-school children with DPT, immunization of expectant mothers against tetanus, prophylaxis against nutritional anemia for mothers and nutritional programme for control of blindness caused by vitamin 'A' deficiency among children were also implemented through Family Planning centres.

The Fifth Five Year Plan sought to integrate Family Planning with minimum needs programme specifically with the programmes of health, MCH and nutrition and outlined modalities for it. Population education was also given greater importance. The need for involvement of 'community' was recognised and a package of incentives were offered for this purpose. This plan period constituted a landmark in the sense that the first ever-National Population Policy was formulated in 1976. Its main features

included (i) freezing of population base at the 1971 level for determining representation in Parliament and State Legislatures upto 2000 AD. (ii) Raising of minimum age of marriage to 18 years in case of girls and to 22 years in case of boys. (iii) 1971 population was to be considered as the base for allocation of central assistance to the State Plans. (iv) Involvement of all Ministries/Departments in making family planning an integral part of their programmes and targets. Through the 42nd Constitutional amendment, Family Planning and population control, a state subject until then, was made a concurrent subject to facilitate provision of central assistance to the States. In 1979, distribution of oral pills was also introduced through trained paramedical staff in the basket of contraceptives. This Plan period also witnessed a major backlash against the Programme because of excesses committed during the emergency which created a strong negative public reaction.

The Sixth Five Year Plan continued to assign a very high priority to the programme but greater stress was laid on the need for motivation, persuasion and education in carrying it out. The role of voluntary agencies, Panchayati Raj Institutions and local bodies was also recognised. It emphasized promotion of all methods of contraception to encourage open choice. PRIs get mentioned for the first time in the Programme Strategy.

The Seventh Five Year Plan noted the lower level of achievements in respect of demographic indicators because of the poor performance of States of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan leading to the usage of BIMARU acronym for them. It stressed the need for inter-sectoral cooperation for delivery of services, community participation for voluntary acceptance and involvement of NGOs and community leaders in motivating the people.

The Eighth Five Year Plan distinctly focused on improving the

socio-economic status of the women through various measures and involvement of Panchayati Raj Institutions in the programme. Special emphasis was placed on mobilisation of private medical practitioners and indigenous systems of medicine. This Plan specifically stressed on building a national consensus with regard to the Family Welfare Programme.

The Ninth Five Year Plan envisaged a paradigm shift from setting up demographic targets to focus on enabling couples to achieve their reproductive goals and from reducing infant mortality to reduce high fertility. It advocated method – specific contraceptive targets to meeting unmet needs of contraception and integrated RCH programmes. It made a policy shift away from centrally defined targets to community need assessment and decentralized area specific micro-planning and from quantitative coverage to quality and content of care, from supply driven service delivery to need and demand driven service and from service provisions based on provider's perception to addressing choices and conveniences of couples. It called for intensified efforts towards involvement of PRIs, General Medical Practitioners in non-government sector and other systems of medicine, industry and labour.

The year 2000 saw the emergence of a national population policy in pursuance of the earlier directions of the Parliament which laid down distinct goals to be achieved and also strategies for this purpose. The approach to the 10th Five Year Plan has distinctly focused on ensuring that families have improved access to health care facilities, providing appropriate high quality of health care to enable them to achieve their reproductive goals. This in turn will enable the country to achieve goals set in the National Population Policy-2000. The National Commission on Population, which has since come into existence in pursuance of this policy, has been assigned a catalytic role in improving Centre/State and

Inter-sectoral coordination and in involving private sector, voluntary institutions and civil society for generating a vigorous peoples movement to achieve the goals set in the policy. It is evident that no focus has been placed on PRIs as instruments for achieving these goals in the plan document although, as indicated elsewhere in this paper, National Population Policy-2000 has earmarked specific components of activities for PRI in the context of its operational strategy.

This brief evolution of population policy attempted above would indicate that the complex and multi-faceted nature of population problem has come to be increasingly appreciated and the strategy to deal with it has taken note of various dimensions, which would have to be integrated in developing a suitable approach. Also, the impact of international movement (Cairo Conference, 1994) on population and development is evident in the acceptance of the language of rights and freedom of targeted persons in the policy documents and official literature on this subject.

In 1983, the first ever-National Health Policy was formulated which emphasized the need for "small family norm" through voluntary efforts and moving towards the goal of population stablisation. While adopting the National Health Policy, the Parliament also desired that a separate National Population Policy be formulated. The National Development Council in 1993 proposed that the formulation of such a policy should take a "long term holistic view of development, population growth and environment protection" and to suggest policies and guidelines (for formulation of programmes) "and monitoring mechanism with short, medium and long-term perspectives and goals". In pursuance of these directives National Population Policy 2000 was brought out. This policy reflects a major departure from the past in calling for an end to a regime of incentives and disincentives (which at the implementation level has translated into

compulsion and even coercion to accept two children family norm). The Policy also accepts the need for convergence and synergy in motivating the agents of programme delivery to be responsive to the needs of women and of the poor. The Policy also affirms the 'commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive care services and continuation of the target free approach in administering Family Planning."

The role of PRIs has came for mention in a small way in para 11 of the document of NPP-2000, where elected women members of the Panchayat have been suggested as Head of Panchayat Committees to promote a gender sensitive multi-sectoral agenda for population stablisation. These Committees will prepare socio-demographic plans and identify areas of un-met needs. Elsewhere, Panchayats have been considered useful for promotional and motivational activities in respect of small and healthier families, educating girls, promoting female participation in paid employment and in monitoring the services and supplies (para 14). PRIs could be rewarded for universalizing small family norm, achieving reductions in infant mortality and birth rates and promoting literacy with completion of primary schooling (para 11). In the annexure to the Policy, under the title operational strategies in respect of twelve themes brought out in the Policy, mention has also been made that Panchayat should appoint a competent and mature midwife assisted by volunteers to look after village maternity hut. While the document has undoubtedly gone farther than any other official policy statement (para 5,) on involvement of panchayats in FW Programmes, it would be evident that the role of PRIs in population stablisation that has been conceptualized, is not in line with the functional jurisdiction the Constitution has conferred on PRIs and reflects the mindset of policy-makers including NGOs in respect of the role to be assigned to PRIs. The utmost they can think of conceding is a supportive role to the larger

designs worked out by others. PRIs are not considered prime movers in this area of activity. Theirs is only a collaborative and supplementary role and not that of a manager of Programmes and as institutions, which are in command of the subject. PRIs have not been positioned as pivot around which the entire programme and services are expected to run.

Some State Govts. have also prepared their Population Policy, prominent among them being MP, UP, Rajasthan, Gujarat, Maharashtra, J&K, etc. But the role these documents assign to the PRIs in their policy frame and operational strategy is even less than what has been articulated in National Population Policy-2000. Most of them merely touch upon the subject in a general way which takes not more than a paragraph. Only M.P. document has articulated it more comprehensively. National Health Policy-2002 has merely provided that the structure of national disease control programmes will have specific components for implementation through local self-governing institutions. But it refuses to come to grips with the adverse effects of the vertical implementation mode of its programmes on access of people to avail of them, which also constrains the population stabilization programme.

The NPP-2000 has distinguished between immediate, medium term and long-term objectives. The immediate objective of the NPP 2000 is to address the unmet needs for contraception, health care infrastructure, and health personnel, and to provide integrated service delivery for basic reproductive and child health care. The medium-term objective is to bring the TFR (Total Fertility Rate) to replacement levels by 2010, through vigorous implementation of inter-sectoral operational strategies. The long-term objective is to achieve a stable population by 2045, at a level consistent with the requirement of sustainable economic growth, social development, and environment protection.

In pursuance of these objectives, the following National Socio-Demographic Goals to be achieved in each case by 2010 are formulated.

National Socio-Demographic Goals for 2010

1. Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

2. Make school education up to age 14 free and compulsory, and reduce dropouts at primary and secondary school levels to below 20 per cent for both boys and girls.

3. Reduce infant mortality rate to below 30 per 1000 live births.

4. Reduce maternal mortality ratio to below 100 per 100,000 live births.

5. Achieve universal immunization of children against all vaccine preventable diseases.

6. Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

7. Achieve 80 per cent institutional deliveries and 100 per cent deliveries by trained persons.

8. Achieve universal access to information/counselling, and services for fertility regulation and contraception with a wide basket of choices.

9. Achieve 100 per cent registration of births, deaths, marriages and pregnancies.

10. Contain the spread of Acquired immunodeficiency Syndrome (AIDS), and promote greater integration between the management of reproductive tract infections (RTI) and sexually transmitted infections (STI) and the National AIDS Control Organization.

11. Prevent and control communicable diseases.

12. Integrate Indian Systems of Medicine (ISM) in the provision of reproductive and child health services, and in reaching out to households.

13. Promote vigorously the small family norm to achieve replacement levels of TFR.

14. Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centered programme.

(Source – National Population Policy – 2000)

The achievement of these goals will require a major improvement in the functioning of several social sector programmes. It would above all require a radical reorientation of approach by Health and Family Welfare workers engaged in delivery of services to their clientele. Obviously, social control over the programme, enforcing accountability of service providers, putting quality of services center-stage and universal access to information, counselling and services for fertility regulation cannot be achieved without giving a pivotal position to the PRIs in the programme because these are the only democratic bodies with links to the people at the grass root level and eventually answerable to them.

Twelve strategic themes have been identified to achieve the socio- demographic goals for 2010. These are:

- Decentralised Planning and Programme Implementation
- Convergence of Service Delivery at Village Levels
- Empowering Women for Improved Health and Nutrition
- Child Health and Survival
- Meeting the Unmet Needs for Family Welfare Services
- Under-Served Population Groups
    - Urban Slums
    - Tribal Communities, Hill Area Populations and Displaced and Migrant Populations
    - Adolescents
- Diverse Health Care Providers
- Collaboration and the Commitments from the Non-Government Organizations and the Private Sector.
- Mainstreaming Indian Systems of Medicine and Homeopathy
- Contraceptive Technology and Research on Reproductive and Child Health
- Providing for the Older Population
- Information, Education and Communication

The Action Plan relating to operational strategies in respect of above themes has been outlined in great detail in the Annexure-I to the policy. Regrettably no focused role has been carved out specifically for PRIs there either even though Panchayats are the only people's

organization at the grass root level with institutional status and spread all over the country waiting to be used. More importantly, these are the only decision making bodies where 'one-third' of positions are held by women which provides them unparalleled legitimacy in handling programmes which overwhelmingly touch upon the intimate lives of women and well being of children. This is particularly galling because leaving aside the item on Contraceptive Technology Research, if substantive results on a continuing basis have to achieved in this Action Plan, PRIs have to be involved in respect of action points related to every theme. This is, therefore, an important omission in strategy. There can be no peoples' movement without PRIs at the centre of it because they should be the instruments of peoples' mobilization. There is even greater reason for them to take direct responsibility of this task because unlike NGOs, private sector or any other segment of civil society, PRIs are democratic bodies which have to go through the process of election and therefore are accountable for their omissions and commissions.

CHAPTER III

The Un-met Needs

The present growth of the population of the country is basically due to three factors. About 58 per cent of the growth can be attributed to the large size of the population in the 'reproductive age group'. This is referred to as the "momentum factor" and is bound to take place because of what has happened in the past. Another 20 per cent of the growth in population is said to be due to un-met needs of contraception and the balance 22 per cent due to other socio-economic factors like high infant mortality, low status of women, preference for son, illiteracy, poverty etc. Higher fertility due to un-met needs for contraception accounts for 168 million eligible couples of which only 44 per cent are currently effectively protected. Thus, urgent steps to make contraception more widely available, accessible and affordable would considerably reduce fertility levels. Around 74 per cent of the population lives in rural areas in about 5.5 lakh villages, many with poor communication and transport facilities. Reproduction health and basic health infrastructure and services often do not reach the villages and accordingly vast numbers of people cannot avail of these facilities. Infrastructure development, therefore, would facilitate eligible couples to avail of these services and thus increase the number of those who are able to reduce their family size.

High wanted fertility due to high infant mortality rate (IMR) is on account of the perception of some segments of population, particularly the poor, who see repeated child birth as an insurance against multiple infant (and child) deaths which stymies efforts at reducing total fertility rate. Additionally, there are more child deaths in the age group of 0-14 in this segment than elsewhere. Further, over 50 per cent of girls marry below the age of 18, the minimum legal age of marriage resulting in too early, too

frequent and too many births. Around 33 per cent births occur at intervals of less than 24 months. This also contributes to high IMR.

India accounts for over 20 per cent world's maternal deaths, which is extremely high at 408 per one lakh of live births. India also shares a distinctive feature of South-Asian and Chinese population regarding adverse sex ratio. In 1991, sex ratio went down to 927 and improved marginally in 2001 to 933. This is largely attributed to preference for son, discrimination against girl child, female foeticide, higher fertility and high mortality levels for females in all age groups upto 45.

The elements of population growth amenable to policy intervention relate to the later two categories, namely meeting the un-met needs of contraception and dealing with the socio-economic and demographic factors affecting population growth. It has been admitted that if the un-met needs for contraception alone can be met in the high population growth states it could go a long way in reducing the overall population significantly.

The report of the working group on un-met needs for contraception has made a number of recommendations, prominent among them include: (i) intervention to meet un-met needs should not be an isolated vertical component but be an integral part of the delivery of basic RCH services and embedded in public health and associated sectors' infrastructure; (ii) extending the basket of choices and improve their easy availability; (iii) linking family planning services to new opportunities arising from decentralisation and economic reforms with panchayats being used for ensuring their accountability and reach; (iv) involvement of ISM & H practitioners to increase coverage; (v) improving quality in all methods of contraception and creating safe back-up abortion facilities; (vi) With the help of NGOs and self-help groups ensuring widest availability of public information on methods of contraception including precautions to ensure

that choices in contraception are in fact available in letter and spirit; (vii) special training programmes particularly in contraceptive safety skills for ANMs, supportive counselling services, efforts to encourage men to use contraceptive methods and sex education to adolescents within a positive value framework; (viii) affordable health insurance package for low income people for a selected number of common illnesses which should cover OPD and also maternity and; (ix) crucial role of Panchayats in providing information to the people and ensuring local accountability.

It would be evident from these recommendations that leaving aside the proposal concerning affordable health insurance for low income people, virtually all remaining prescriptions are already included in the package of existing programme. The Group has also laid stress that Panchayati Raj Institutions have a crucial role to play in implementing these recommendations. Health being one of the subjects which fall within the domain of PRIs, Panchayats have a major role in ensuring that the health care system functions properly in their jurisdiction. Similarly, in the matter of people's mobilisation, counselling and information dissemination, Panchayats have a great advantage over bureaucratic machinery. In fact, even on the question of an insurance package, once PRIs are empowered, some enterprising Panchayats can take a lead and develop an insurance package for targeted population appropriately funded from their own resources or with contribution taken from beneficiaries rather than waiting for an All India Initiative to emerge on the subject. It is for innovations like these and not merely for other identified activities including infrastructure development that capacity building has to be attempted for PRIs.

Among the 14 national socio-demographic goals of national population policy first 7 relate directly to the women and children and the remaining 7 relate to them indirectly, although vitally. The sub-group on empowerment of women, development of children and issues of adolescents made the following major recommendations

- The larger issues of alleviations of poverty, empowerment of women, changing mind-set of men and creation of opportunities and enabling environment for women, children and adolescents have to be addressed. Strategic framework for stablisation of population is not merely a question of birth control or use of contraceptives.
- Various national policies such as those of health, youth education, and children should all be integrated with national population policy for preparing national and state level action plans.
- Adequate resource allocation for social sectors.
- Universalisation of ICDS and IWEP programmes, opening up of large number of crèches / day-care centres.
- Restructuring of Kishori Shakti Yojana so as to have a gender centered adolescent nutrition and development programme.
- A strong focus on adolescents in various programmes and schemes.
- Nutritional scheme for children and mothers in the below poverty-line segment through available food stock.
- Women members of Panchayats to coordinate various programmes of women and children and capacity building for this purpose; Empowerment of the self-help groups of women; collaboration of Panchayats, NGOs and self-help groups in social sector programmes.
- Positive discrimination in favour of districts and blocks which have lagged behind so as to accelerate their development to reach the minimum desired levels. Developing a system of gender segregated data on indices of development at district and sub-district level.
- Medium-term perspective of 10 years for empowerment of women and development of children and adolescents.
- Involvement of men in promotion of reproductive rights and greater focus on male contraceptives as safe and easier device to use.

- Training and equipping the village midwives to ensure 100 per cent safe deliveries.
- Promoting Rural orientation for medical students of both government and private colleges.
- Training and capacity building of field functionaries, NGOs, self-help groups in addition to members of PRIs.
- Comprehensive package at block level on improving home based care through trained personnel for checking neo-natal and pre-natal mortality.
- Compulsory social auditing of infant and maternal deaths.
- Clinical and medical interventions which can result in immediate and significant improvement in the maternal mortality to be effected through campaign mode.
- Review of pre-natal diagnostic Act to ensure its effective implementation.
- Sustained information campaign for achieving national goals contained in NPP-2000.
- Suitable packages and courses on health and nutrition education.

In respect of a large number of above recommendations, the jurisdiction of Panchayati Raj Institutions is obviously attracted and PRIs, if adequately motivated, energized and empowered, can pursue them within their jurisdiction without waiting for a national initiative. It has also been recognised in the group's report that elected representatives of Panchayati Raj Institutions are better placed to ensure their implementation provided they are properly trained and there is requisite devolution of power, authority and resources. The Working Group on PRIs fully endorses this view.

CHAPTER IV

Decentralised Governance: Does it matter for Population Stabilization

Population stabilization cannot be viewed in isolation. It is a dependent variable linked to the quality of environment, improved status of women, education, sustained and secure employment, equitable economic growth and income distribution and good living conditions. Therefore, programmes such as eradication of poverty, improving access to food, education and health care, providing adequate housing, sanitation and drinking water and improving the status of women through welfare and literacy programmes are necessary conditions for promoting population stabilization. The 73rd constitutional amendment, which prescribes uniform structure of local governments throughout the country, provides the basis for conceptualising the role of PRIs for local self-governance and development. The 74th amendment to the constitution incorporates the provision for a district planning committee, which among others, is required to issue guidelines for local level planning by PRIs. These amendments have created a framework for enabling the state legislatures to determine the scope of devolution of funds and powers to the local bodies. The Eleventh Schedule to the Constitution incorporates the list of 29 subjects allotted to the PRIs. Item No.24 in that list is 'family welfare'. Thus the subject of Population Stabilization clearly falls in the domain of PRIs. Even the subjects pertaining to other dimensions of development such as those listed in the preceding paragraph which have a bearing on Population Stabilization are also included in this list as would be evident from Box.1.

Box 1 : Functions of Panchayati Raj Institutions (XIth Schedule)

(11) Drinking Water;
(16) Poverty Alleviation Programmes;
(17) Education;
(23) Health & Sanitation including Hospitals; Primary Health Centres & Dispensaries;
(24) Family Welfare;
(25) Women and Child Development;
(28) Public Distribution System.

The approach paper of the Planning Commission on the Ninth Five Year Plan (1997-2002) had committed that the efforts would be intensified to enhance the quality and coverage of family welfare services through "involvement of Panchayat Raj institutions for ensuring inter sectoral coordination and community participation in planning, monitoring and management", although medical practitioners in voluntary and joint sectors, industries in the organized and the unorganized sectors and labour representatives have also been bracketed with PRIs for such involvement. It only goes to show that even this National Policy document on planning in the country has failed to recognise the over arching and pre-eminent status of PRIs in this endeavour because these institutions alone can mobilise medical practitioners as well as industry and labour unions. The expert group set up to draft the National Population Policy under the chairmanship of Dr. M.S. Swaminathan in its report of May, 1994 clearly stated that the present vertically structured family welfare programme needs to be replaced by decentralized, democratic planning through Panchayats, Nagar Palikas and State Legislatures. The report indicated that the elected Panchayati Raj and Nagar Palika institutions are best suited to promote such decentralized action. These structures provide not only

'unusual opportunities for correcting the prevailing gender imbalance in the acceptance of contraceptives' but are also in a position to prepare a socio demographic charter for the respective village, town or city with specific goals for population stabilization. This charter will also indicate steps which the local community plans to initiate for eradicating social evils like female foeticide and infanticide, child marriage, dowry and female and male literacy apart from improving quality of life. The report also envisaged that these local bodies will mobilise local resources, particularly in kind, to promote these programmes.

Population stabilization is the long-term desired goal. Multi sectoral development action would be required to influence the processes which help in reaching this goal. Health is a very critical sector in these arrangements. In the existing arrangement of allocation of responsibilities, health system right from sub-centers to the district hospitals including family welfare apparatus falls in the domain of PRIs. It is expected that PRIs would promote public participation in health and family welfare management and develop strong affinity and ownership feeling towards institutions and programmes associated with them. Micro level democratic structures like Gram Sabhas can provide space for in-depth discussion of the health problems of people in villages including possibilities for improving the service provided by the health care institutions. The service providers - doctors, para medics and health workers, could also join to give their expert opinion and gather feedback about the problems and perceptions of the people regarding services provided by them. The gram sabhas can also assess the resource potential for solving health problems and on that basis prioritize possible solutions. Gram Sabhas are uniquely placed in promoting convergence between public health and family welfare programmes and other development areas such as sanitation, hygiene, drinking water, immunization, nutrition and education. They are

best suited to ensure availability and accessibility of health care services through a more responsive behaviour and work culture among service providers. The non-health factors which impinge upon the health outcomes can also be effectively combined in the discussion at the gram sabha level and would provide a framework for an integrated health strategy. The health personnel present in such meetings would also get an opportunity for working out creative ways in which public health and family welfare can be promoted taking into account the local resources and the specific nature of local problems and peoples' behaviour. This interface would bring up innovative ideas and practices.

Over the years, the share of public spending on health is declining largely due to financial crisis faced by the State Governments. As a consequence, the quality of service provided by the public health institutions has been deteriorating. The better off sections of society have started patronising private health care institutions. However, due to high cost, the poor cannot access these institutions and facilities, though the unsatisfactory functioning of public health institutions has forced even the poor to spend considerable part of their meagre and hard earned income on health care rendered by the private sector which would have ordinarily contributed towards better food and nutrition of the family. The challenge before PRIs is how to correct the existing inequities in health care services and to transform through community participation the public health institutions as centres for efficient delivery of services, with concern for the underprivileged, user friendly behaviour and greater sense of accountability. This, however, would require that the capacity to discharge this role be built up in the PRIs. PRIs are a set of democratically elected structures of self-governance at three levels. The entire health and family welfare activities are not managed at the village / panchayat level. It would,

therefore, imply specifying functions and responsibilities to be discharged at each level alongwith allocation of resources consistent with them. The principle that needs to be kept in mind while specifying functions for the three tiers is that "what can be done at a given level shall be done at that level only and not at higher level". The gram panachayat level, broadly speaking, can efficiently handle family welfare centers, primary health care centers, sanitation, immunization and preventive / promotive public campaigns in the health domain and activities concerning literacy, poverty alleviation, nutrition and income generation in the non-health segment. This level would also be crucial in forging linkages with specialized / referral health services at higher levels. The block panchayat would be better suited to deal with community health centers / Taluk hospitals as referral units for in-patient treatment. The block panchayat can also organize capacity building programmes for health personnel at the gram panchayat level and get literature prepared for health education, proper storage and distribution of medicines, arranging for specialist services to PHCs, linkages for attending to emergency cases etc.

The District Hospitals of various systems of medicines will be managed by district panchayat which would also look after training needs of medical professionals in PHCs/CHCs and Taluk hospitals. The district hospital will function as a referral center for attending to serious cases which are not possible to treat in the CHCs and as institution for training of para medics. The District Panchayat will maintain mobile units and provide their services in times of epidemics, for communicable diseases and medical camps organised in various centres. The District Panchayat will also be responsible for procurement of essential drugs which are not supplied by the State Government./Government of India directly, storage and distribution of drugs to PHCs, CHCs, sub-centres and supervise sale of drugs in the market for quality and price.

The entire range of health programmes within the District would be coordinated by the District Panchayat with the active support and involvement of gram and block panchayats and help of technical experts available in the district. It would also mobilise, where necessary, specialist personnel from medical colleges and other sources including private practitioners/nursing homes and deploy them for specific periods at places where their need is acutely felt. The district panchayat will have to effectively intervene in programmes of sectors other than Health, like agriculture, rural development, education, sanitation, drinking water, nutrition, etc., to promote convergence of services for improving the health status of people. The District Panchayat would also interface with voluntary organizations and health care providers in the private sector for promoting partnership and cooperation. The PRIs would not merely discharge the responsibility for managing health care institutions and providing services in public health and family welfare; they would also be required to prepare a properly worked out health policy for their area which reflects the local needs and aspirations and backed up by local resources to supplement the allocated funds. The management of health care Institutions and programmes cannot be carried out unless those entrusted with that responsibility have a decisive say in the policy defining their role and methods of their operations.

The PRIs, therefore, would be policy making bodies in their own jurisdiction. To discharge this role, they would have to gather necessary information, interact with technical personnel, consult local people through various Institutions in which they participate and associate experts and non-experts outside the Government. The broad areas in which such a policy planning exercise would be based should include, among others, assessment of their powers and responsibilities in public health and family welfare, resource availability at each level, objectives set out in the area of

public health and family welfare, important health issues articulated by people, functioning of health system including its deficiencies, demographic status, resources which can be additionally mobilised, status of private/voluntary health care providers, areas where non-health sectors impinge on health related problems and specific nature of interventions required, responsibility which each PRI can discharge within the constraints of its situation etc. Health Policy and Action Plan can be prepared on this basis by each PRI.

Involvement of PRIs – The Rationale

So far Family Welfare Programmes have been administered entirely through bureaucratic formations. While this has had limited achievement, the goal of population stabilization requires these efforts to be accelerated. This would mean greater participation of target group couples in the programme with a view to understanding what constrains their behaviour in acceptance of small family norm and using various devices available for this purpose and how these constraints can be neutralized. As a necessary pre-condition, this would require more intensive and continuing contact with and counselling of the targeted couples and ensuring delivery of services and products to them. On both these counts, existing institutional arrangements have produced sub optimal results, despite burgeoning expenditure. In this background, the rationale for an alternative mode of delivery of services assumes significance. A number of persons who have been involved with the programme consider vigorous involvement of PRIs as the alternative organizational route. This would have the following advantages:

- The PRI bodies would be able to oversee the working of the bureaucratic delivery system for the programme and thus providing

the much needed guidance and critical inputs in terms of feedback from people. This would make the bureaucracy at the grassroots more alert and accountable. The political control over the programme at the cutting edge level would thus get energized and strengthened.

- Involvement of PRIs would provide opportunities for more intimate interface with target group couples, particularly women in the family which would permit their genuine and context specific/group specific problems to be articulated. On this basis, corrective measures accommodating their concerns can be initiated without much delay at the local level itself.

- It is widely recognized that population stabilization is a complex goal which would respond to a multi sectoral development thrust. This presupposes different sectors of Government coming together and working in a coordinated manner so that convergence of services can create the necessary impact for motivating a change of behaviour. Though such an approach has been advocated by Govt. representatives and critics alike, its realization has remained elusive since bureaucratic formations are prone to work in a segmented manner through their departmental hierarchies. This limitation is expected to be overcome substantially once elected bodies like PRIs take charge of the programme and involve themselves in monitoring and supervision as all concerned public functionaries would eventually submit themselves to their political directions.

- Peoples involvement through PRIs at various levels in the programme would create more humane ambience in the delivery of services where human rights and concerns of dignity are respected both in thought and action and developmental dimensions of fertility are taken into

account while devising strategy for tackling the socially constrained behaviour of targeted couples/groups.

PRIs are the third tier of Government after the coming into force of 73rd Amendment to the Constitution which has empowered them with a clearly defined jurisdiction followed by its reinforcement through the concerned State law. Twenty-nine subjects which broadly encompass all sectors of development relevant to the concerns of the rural population have been allotted to them. Apart from health, education is the other sector that has an important bearing on population growth. A study on the relationship between female literacy levels and child population carried out in some blocks of West Bengal * has brought out that there is a threshold level of female literacy (30%) beyond which the size of the under six population declines rapidly. Similar studies in respect of other States could identify areas of specific interventions by PRIs concerned. Other sectors that have the potential to influence the process of population stabilization are also within the jurisdiction of the panchayats. PRIs are, therefore, constitutionally entitled to deal with family welfare and related programmes to make a decisive impact on their outcome. But to discharge this responsibility, they require allocation of resources, control over local staff and delegation of executive powers for implementing schemes and authorization of expenditure. That it has not happened even after a decade is due to political resistance from the concerned State Governments, both political and bureaucratic wings. There is progressive realization that this devolution should be effected without delay and there is nothing radical in this approach. It is merely a reiteration of what the State Governments are in any case mandated to do. Continuing pressures need to be exerted on the State Governments to move in this direction

* Satish B. Agnihotri - High Female Literacy, low child population; Is there a threshold effect?

The decentralized decision making would improve the delivery system in respect of all development programmes and more specifically those relating to health and family welfare since inadequacies of the system to deliver services to those in need is a major factor in sub-optimal achievement. The fact that there is considerable backlog (estimated at around 20%) of the 'unmet needs' further strengthens the assumptions that without much talked of peoples' mobilization, substantial gains cannot be registered in the programme. Logistical bottlenecks in delivery of services can only be removed effectively through local interventions. While such interventions would no doubt depend upon authority, powers and resources delegated to PRIs, some striking improvements can be effected even pending such devolution. Steps to correct gender imbalance in acceptance of contraceptives, fair treatment to the girl child including mobilisation against female foeticide, social audit of infant and maternal mortality, empowering the local birth attendant with training etc. are some of the areas where PRIs can intervene straightway.

There is a reservoir of talent in the PRI members which needs to be explored and tapped for this work. At present, the attention of these bodies is almost exclusively concentrated on more populist activities of infrastructure development and distribution of government assistance to the target groups. A focused reorientation of community leaders for devoting attention to Health & Family Welfare Programmes is therefore called for. The talent for this purpose may be spotted in women members of panchayat, self-help groups, neighbourhood help groups, women school teachers, women social workers, NGOs, Mahila Mandals and other rural organizations. These women need to be empowered for carrying out specific tasks with appropriate training and information and with other with back up support. The process of such empowerment could be accomplished by taking the following steps.

- Pushing the programme of health and family welfare on the political agenda at the top. Enabling PRI members to perceive the political benefits flowing from it may facilitate this shift.

- Providing resources, delegating executive powers and transferring control over staff and other public functionaries under the programme.

- Organising training to cover the following aspects:
    - o Knowledge about how the programmes are administered and services provided.
    - o Techniques of peoples' mobilization
    - o How to effect inter sectoral coordination and effect convergence of allied programmes
    - o Ways of effective and efficient utilization of available resources
    - o Generation of local resources - monetary, manpower and material
    - o Specific responsibilities which could be discharged in the absence of requisite delegation
    - o Where and how they can look for back up support.

- The vigorous involvement of PRIs would facilitate the concerns of health, family welfare, equitable development and population stabilization getting incorporated in the local political discourse in the same manner as various other development dimensions such as

creating infrastructure, employment generation etc. are done at present. This will generate requisite awareness among the people, which would raise / sharpen their demand for various services. The raised consciousness in turn would create pressure on the elected bodies as well as local bureaucracy to perform which would make them more responsive. Involvement of PRIs would also lead to institutional capacity building in respect of this programme that would generate its own momentum.

- With the involvement of PRIs, innovative and practical steps/solution may emerge for meeting local problems affecting family welfare and related programmes which are otherwise not likely, given the straightjacket rule bound world of official delivery system. Involvement of PRIs may also help identify variety of situational constraints and sensitivities, area as well as people specific and would therefore pressure them to work out differential strategies to meet them, which are user friendly and easier to implement. Such experiences would also create demand for greater freedom of action in activities such as modes of social mobilization, IEC, strategic entry points in areas of intense hostility towards the programme without alienating the power structures of the community and may eventually change the overall contours or the programmes and strategies at the policy making level. PRIs' involvement would thus help crystallize appropriate approaches to extension of programme activities focusing on specific target groups and communities.

- As per the new Bible of governance in the globalised world, public and private partnership is now the most recommended strategy in development, ever since the international financial institutions have started determining/influencing the development policy. No area of

activity is friendlier or more fertile than the broad field of population stabilization for promoting public-private partnership since there is a general convergence of opinion on the goals to be achieved. PRIs would be better suited than bureaucratic organizations for facilitating this partnership. Midnapur project is a good example of what such a public-private partnership can achieve in the field of sanitation. A recent study# has collected many instances of such partnerships in improving public services.

- With PRIs in command of the programme, elected representatives of people may be pressured to alter their own behaviour pattern voluntarily on the issue of small family norm as an off shoot of the political dynamics to put up their best foot forward and to avoid adverse scrutiny from the constituents. This would help followers to imbibe norms of behaviour which they are seeking to see reflected in their leaders. Such a process may lead to an overall behaviour change in the society, albeit slowly.

A large number of working groups were constituted for recommending course of action to achieve the medium and long-term goals of population stabilization. The recommendations of other groups include inputs by way of micro level policies and prescriptions This group on PRIs and self-help groups is the most crucial of all because suggestions of other groups would eventually involve or get implemented through the PRI bodies and their relevance and utility would largely depend upon the efforts of the PRIs to translate into reality ideas contained in them. Peoples' mobilization is the key to the success of these efforts. With the help of civil society formations such as self-help groups, Community Organizations, NGOs, social activists, PRIs can accomplish such mobilization.

#Malcolm Harper, Public Services through Private Enterprise (2000)

CHAPTER V

Population Stabilization: Strategic Immediate Steps

As per the National Population Policy Document, the present growth of the population of the country is basically due to **three** factors. Large size of the population in the 'reproductive age group' also termed ' the momentum factor ' is the major contributor. This is bound to take place because of what has happened in the past. **Unmet needs** of contraceptions and the other **social-economic factors** like high infant mortality, low status of women, preference for son, illiteracy, poverty etc. are the other contributory factors. The element of population growth amenable to policy intervention relates to the latter two categories, namely meeting the unmet needs of contraception and dealing with social-economic and demographic factors affecting population growth. It has been recognized that if the unmet needs for contraception alone can be met in the high population growth states it could go a long way in reducing the overall population significantly.

Unmet needs represent the gap between women's reproductive intentions and their contraceptive behaviour. It also signifies that having become aware of contraceptive availability, some women do not accept it or having accepted the need, do not proceed to use contraception. Unmet needs are identified as a separate category within family planning services in order to focus on such married women who share the attitude of contraceptive users but their practices do not conform to them. This may be due to fertility related or method related problems or due to opposition from husband and family or due to lack of access to contraceptive devices. It is, therefore, felt that removal of such impediments will increase contraceptive use and will lead to fertility control. Unmet needs

are not a static concept but an evolving one. It does not relate to only women who want contraceptives, which is merely a function of supply of product, but those women who require motivation to want what they are presumed to need. Therefore, strictly speaking, the contribution of unmet needs to population growth that has been assessed at 20 % may be a conservative estimate as it supposes that all those contraceptive user women, whether their use is effective or not are able to meet their contraceptive needs. This may not be the case as some women may be using ineffective methods or using a method incorrectly or their use of methods may be unsafe. The concept of unmet needs would seem to cover all such cases. Thus the number this category covers is quite large.

The unmet needs of family welfare may be on account of several reasons, prominent among them include ignorance, lack of access to information, services, health facilities or fear of higher risk from side effects of fertility control devices. In this view of the matter, unmet needs emerge from the following factors:

a) Availability, access and quality of existing health infrastructure and family welfare services. This would include motivation and mobility of health providers and transportation of patients to health centers.

b) Counselling

c) Supply of products

d) Information / education

Therefore, intervention to meet the unmet needs cannot be construed as a component of RCH programme but has to be positioned integrally in

the country's public health and associated nutrition and child development infrastructure. Taking the above into account, the National Population Policy 2000 has conceptualized three dimensions of possible interventions:

Sharpening the focus on existing infrastructure to deliver the quality of services is the first point of intervention. This should be accomplished by following steps :

- energisation of health and family welfare infrastructure at the village, sub-centre and primary health center levels to function as a caring system and motivation of personnel at the cutting edge
- improving penetration into rural areas, urban slums among vulnerable groups.
- arranging transportation for referral patients
- increasing easy availability and efficient distribution of affordable contraceptives
- communicating comprehensive information through user-friendly methods of advocacy.

This is also the substance of recommendations of working group set up by the National Population Commission on unmet needs. Further elucidation of these recommendations imply better planning, resource mobilization and co-ordination under on going contraception programmes with emphasis on synergy in related programmes to achieve optimal results. Also, added in this context is wider and easy availability of contraceptives, expanding basket of choices consistent with safety and concern for human rights and accompanied by comprehensive information cutting across geographical areas and classes through the community based outreach and

coverage. There is also a suggestion that family welfare services should also include health insurance. Monitoring of quality of services and enforcing accountability of service providers have been stressed and the role of Panchayats has been specifically thought of in this context.

The second dimension of intervention outlined in the operational strategy has been linked to the inadequacy of the existing health infrastructure to meet the unmet needs of contraception, their being wide gaps in coverage and outreach. This implies that health care / family welfare centers are over burdened or under-provided in terms of personnel and equipment, besides being constrained by absence of supervision, lack of training and motivation. National Population Policy document has identified gaps in the infrastructure, sanctioned and appropriately trained health personnel, provisioning of essential equipment and drugs at various levels which would require huge investment to meet them. The working group has also stressed on strengthening the Public health infrastructure and expanding arrangements for counselling and organization of supplies and services. It has specifically pleaded for additional central funds to five backward states.

The third dimension of the unmet needs is the inability to provide integrated services delivery for basic reproductive and child health care. This is reflected in segmented nature of service delivery related to RCH and family welfare which do not seem to get coordinated to provide delivery at one convenient place. This is on account of inadequate number of trained birth attendants, non-availability of facilities for safe delivery and expert medical advice in case of complications. A key feature of integrated service delivery has been identified as the registration at village level of births, deaths, marriages and pregnancies and maintaining a list of community midwives and trained birth attendants, village health guides, anganwadi

workers and other public functionaries who may be entrusted with specific responsibilities in attempting to implement the integrated service delivery. The one stop integrated delivery would involve package for basic health, family planning and maternal and child health related services. The strategic interventions in this regard include training and motivating village self-help acceptor groups for establishing primary contact at house hold levels who would provide following six different services at one place:

1. Registration of births, deaths, marriages and pregnancies
2. Weighing of children under 5 years and recording the weight on standard growth chart
3. Counselling and advocacy for contraception besides free supply of contraceptives
4. Preventive care, with availability of basic medicines for common ailments, anti-pyretic for fevers, anti-biotic ointment for infections, ORT/ORS for childhood diarrhea together with standardized indigenous medication and Homeopathic cures.
5. Nutrition supplements Advocacy and encouragement for continued enrolment of children in schools up to the age of 14.
6. While some of the functions such as those listed as 2 & 5 above are already performed by the Anganwadi workers at the village level and ANM at the group of villages level, it has been suggested that the village Anganwadi Centre may become the pivot of basic healthcare activities, supply of contraceptives, counselling, nutrition, supplementation and education including pre-school activities. The Anganwadi centers can also function as depots for ORS / basic medicines and contraceptives. Trained birth attendants and dais should be made familiar with emergency and referral

procedures to assist ANMs to respond to maternal morbidity emergencies at the village level. The nearest institutional healthcare facility should be equipped for integrated service delivery to be accessed. A maternity hut should be established in each village as the village delivery room, adequately equipped with kits for mid-wifely, ante natal care and delivery, basic medication for obstetric emergency aid, contraceptives, drugs and medicines for common ailments and indigenous medicines / supplies for maternal and new born care.

As regards the first and third dimension, it is evident that the interventions lie in activating the existing health infrastructure and family welfare services for better performance, enforcing quality, making service providers accountable for their performance and rationalizing deployment of local resources, manpower as well material for extracting optimal benefits. The interventions also include extension of reach of services through co-operation with NGOs and, where feasible, with facilities in the private sector. Barring those aspects which involve adequate allocation of resources such as supply of medicines, equipment etc., Panchayat Raj Institutions are best equipped to make those interventions in varying degrees depending upon the devolution of powers, authority and resources. The village Panchayats can specifically discharge the following responsibilities:

1. Re-organization of existing healthcare infrastructure and family welfare services through rational deployment of manpower and other resources to ensure their optimum spread and performance within their jurisdiction.
2. Monitoring the delivery of services to ensure their access, quality and responsiveness; development of appropriate norms of accountability and beneficiaries participation for this purpose.

3. Intensive training of existing birth attendants and additional birth attendants and integrating them with primary healthcare infrastructure and family welfare services.

4. Making Anganwadi Centre as a pivot of activities for maternal and child healthcare with adequate training, motivation and confidence building measures so that to a large extent such centers can provide optimum possible services at the village level.

5. Identifying public health centers (PHCs / CHCs) where specialized services experts are available for attending to critical cases and emergencies; in the absence of requisite facilities not being available from the district or the state level, to arrange on part-time basis visits of such specialists from private / NGO healthcare centers.

6. Integrating private healthcare center / NGOs facilities in a manner that ensures widest reach and optimum utilization of resources.

7. Arranging extensive counselling to the targeted groups by mobilizing local women on a 'volunteer' basis but with appropriate training, motivation and recognition. Similar efforts for counselling men.

8. Arranging for registration of deaths, births, pregnancies, marriages at the village level; social audit of cases of infant and maternal mortality.

9. Ensuring that basic medicines for essential obstetric aid and common ailments supplied by the Govt. are either stored / available with Anganwadi workers / ANMs or that such medicines are available at the local chemists shop.

10. Mobilise transportation facilities for patients to referral units by arranging public transport where feasible and by encouraging local youth to start such services by linking it up with poverty alleviation programmes under which transport as income generating activity is usually financed.

11. Mobilising women workers in public services and in the non-governmental sector for discharging certain specified responsibilities in the overall programme.

12. Dissemination through user friendly methods and in local dialect of comprehensive information relating to preventive healthcare and nutrition, small family norm, contraceptive devices, treatment of girl child on the widest possible scale through their own elected women members, NGOs, self-help groups, DWCRA units, community organizations, religious organizations, marketing committees and at Haats, bazaars and melas etc.

13. Ensuring universal coverage of immunization and prophylactic measures through key functionaries such as Anganwadi workers appropriately aided and supported by birth attendants, self-help groups and other community organisations.

14. Identifying areas of morbidity requiring specialized attention under various National Disease Control programmes and establishing linkages / contact with service providers for their treatment; so that a schedule is prepared for attending to such cases in PHCs / CHCs as the case may be, and this schedule is widely publicized so that services can be provided with adherence to the schedule.

15. Utilising women Panchayat members, self-help groups, NGOs and

other social workers for widening the reach and access to information and services for family welfare, in particular enlarging the area of unmet needs, appropriate and safe use of contraceptives and neutralizing constraints in taking recourse to regulatory measures for controlling fertility consistent with respect for human rights.

It would thus appear that even in the absence of adequate empowerment of Panchayati Raj Institutions with resources, powers and control over personnel there is a large space available for them to operate and to help in meeting the unmet needs of contraception and services. This role can be discharged even better with suitable capacity building and training measures the details of which have been spelt out in a separate chapter of this report.

Now coming to the second dimension i.e. regarding the inadequacy of existing health infrastructure and the wide gaps in coverage and out reach of family welfare programmes on this account, the deficiencies in health infrastructure and specialized and trained manpower has huge implications for public funding since the existing infrastructure is largely in the public domain. The gap in infrastructure is (a) due to non-filling up of existing / sanctioned positions and inability to adhere to existing level of maintenance (b) additional facilities needed to cover unreached areas and populations and to fully cover the existing area.

Planning Commission have expressed the view that the existing infrastructure is functioning sub-optimally and the factors responsible are:

a) Multiple tiers of institutions

b) In-appropriate location, poor access and poor maintenance

c) Gaps in critical manpower, mis-match between personnel and equipment

d) Lack of essential drugs / diagnostics

e) Poor referral linkages

There are also substantial differences between states and between districts in the same state in the availability and utilization of healthcare services, even though norms for creation of infrastructure and manpower are similar throughout the country.

The strategy suggested by Planning Commission for the optimal utilization of this infrastructure lies in : -

a. Appropriately relocating sub-centres and PHCs to maximize their use

b. Utilisation of funds from various rural development programmes for improving the maintenance of existing facilities.

c. Making ad-hoc arrangement for deployment of doctors, specialists and para-medical staff.

d. Using existing doctors in ISM&H to deliver basic services

e. Improving arrangements for counselling, supply and services with flexibility and responsiveness.

f. Undertaking extension of existing services into inaccessible areas and among the vulnerable groups where necessary with support of NGOs.

g. Development norms for accountability and supervision

h. Designing information / education and communication including face to face counselling suiting local needs and taking into account conceptual constraints.

From the above it may be seen that the strategy suggested by the Planning Commission can best be operationalised by Panchayati Raj bodies within their jurisdiction and does not entail additional funding. It is not our argument that the healthcare and family welfare sector does not need additional funds and manpower. It does, more so because the poor rely on public infrastructure largely and it is the poorer sections who face the constraint of unmet needs most and should therefore constitute the focus for bulk of the unmet needs segment. The strengthening of public sector infrastructure is very crucial for this purpose and this is particularly so in respect of major states [also regarded as Backward States] where unmet needs are the highest. Of these states, Bihar and UP need special mention where only 50 % of the demand for family planning is satisfied. NFHS-II estimates the coverage even lower, i.e. roughly 25 % in both the States. These states also have the largest concentration of population below poverty line. Therefore, strengthening the public health system besides improving the existing ones, is a vital need and also a priority which would require some financial inputs to accomplish. In fact, some of the gaps in critical manpower in these states, as also in a few others, are on account of non-recruitment to the posts already sanctioned. Therefore, even if no additionality of expenditure was committed in creating new positions, filling up the existing positions in the posts of ANMs, women health workers, lab technicians, specialists etc. would lead to considerable improvement.

The second area concerns grants to health care institutions for maintenance, diagnostic equipments, medicines etc where there has been a decline in allocations due to resource problems faced by States. This is an all India problem but particularly critical with some states. A number of them have taken recourse to external funding to meet this gap. Bihar is deficient in this respect as well. The point being made here is that Panchayati Raj Institutions are best equipped to intervene in respect of this dimension of unmet needs also. They can put up pressure for filling up existing posts and for equitable distribution of personnel through rationalization and re-deployment across the State in a manner that critically deficient areas are enabled to satisfy their needs at least partially. They can also strongly advocate for additionality of funds and manpower, particularly funds coming in from Govt. of India in Rural development, Health, Welfare and Women and child development and make a case for specially funded / donor assisted projects. Being democratic bodies, their advocacy would bring this issue on the political agenda to which the policy makers at the sate level cannot remain immune. Further, Panchayati Raj Institutions can appropriately mobilise social groups within their jurisdiction and vigorously network with PRIs across the State to exert pressure on the State Government. Such networking can also be carried out cutting across state boundaries for exerting pressure on Central Government to make special allocations for States deficient in infrastructure and services.

As for the third dimension of intervention, i.e. on the Socio-Economic front for population stabilization, it was that around 20 % of the growth of population is due to factors like high infant mortality, low status of women, preference for son, illiteracy and poverty. In case of infant mortality it has been estimated that about 7 % of new born infants die within a year. This is attributed to (a) poor health of mothers and infants resulting in low birth

weight and pre-mature babies, (b) infant and childhood diarrhoeal diseases, acute respiratory infections and malnutrition, (c) in India, there are more female deaths in the age group of 0-14 than in any other country. With 16% of world population, India accounts for over 20% of world's maternal deaths. Maternal mortality ratio is very high at 408 per 1-lakh live births and this is far higher than even in Pakistan, not to speak of countries like Thailand or Indonesia. Of course, the tiny Sri Lanka is much much better.

The infant mortality rate and maternal mortality rate, to a large extent, are related to the reach and quality of basic health services and status of healthcare infrastructure for reproductive and child health. The suggested interventions for improvement in the health care infrastructure as discussed in the unmet needs section would naturally have their impact on lowering infant mortality as well as maternal mortality. This would lead to better infant survival rate which in turn would motivate the women (in fact the family) to practice small family norm as it would obviate the need for more children as an insurance against risk of death of their infant / children. But fertility behaviour of women and the attitude to acceptance of its regulation is also influenced by complex socio cultural determinants of women's health and nutrition which have a cumulative effect on her status and psyche. These include discriminatory childcare leading to mal-nutrition and impaired physical development of the girl child, under nutrition / micronutrient deficiency in early adolescence which has an adverse impact on the level of productivity in women and therefore, responsible for their poverty as well. Early child bearing and consequent serious pregnancy related complications also increase risk of pre-mature deaths and disability. Mal-nutrition, frequent pregnancy, unsafe abortions, RTI and STI, all combine to keep the maternal mortality ratio so high in India. The added problem in this context is the low social and economic status of girls and women which limits their access to education, nutrition

and healthcare and skewed distribution of these benefits within the family. The programme intervention to combat maternal mortality and infant mortality include safe motherhood, universal immunization, child survival and oral rehydration which together constitute the integrated reproductive and child health programme (RCH). It also includes management of RTIs and STIs.

The operational strategy recommended by the National Population Policy are includes, effective implementation of RCH programme, opening more child care centers to encourage female employment, reducing school drop outs and promoting school enrollment for the girl child, reducing wastage of energy in collecting fuel wood, fodder and potable drinking water and accessing concerned programmes for these purposes besides promoting energy saving devices such as solar cookers and provision of sanitation facilities, improving health management by strengthening referral network, strengthening community health centres to provide emergency obstetric and neo-natal care, establishing mechanism for identification of problem cases of maternal and child healthcare, arranging transportation to improve access to community health centers, improving accessibility and quality of maternal and child health services, monitoring performance of maternal and child health services, improving technical skills of Medical / Para-medical personnel for maternal and child healthcare, effective dissemination of information regarding good management practices for safe motherhood, development of partnership in family health and nutrition through convergence of nutrition programmes of the department of family welfare and the ICDS of the women and child development department and inclusion of STD and RTI and HIV / AIDS prevention in MCH services, designing a health package for adolescents; expanding availability of safe abortion care; setting up maternity hospitals/ wards at sub-district level and at CHCs to function as FRUs, formulating

standards for clinical services in public, private and NGOs sectors, focusing on extension of non-clinical methods of contraception, creating a national network of public, private and NGOs centres for delivery of RCH services free to any needy client.

In respect of the subjects discussed above, Panchayati Raj Institutions have a preeminent role. In giving greater effect to the recommendations of NPP, particularly those listed in sub-item (iii) in Annexure-I to the NPP-2000, such as 1,2,3,4,5,6,7,8,10,11,12,13,14,16,17 except items no. 2,9,13 [only some items],14,15 which require intervention at a higher level, the PRIs in respect of all other suggested measures can effectively discharge the responsibility with the help of their women members, self-help groups, community organizations, NGOs, private sector establishments etc. In fact, most of these items can best be implemented only through such democratic bodies as the PRIs because they have contacts with people and are in a position to mobilise community participation without cost. More important, they can promote suggested convergence of various programmes and services recommended in the National Population Policy.

In respect of child health and survival, National Population Policy document recommends measures focusing on community activities to monitor ante natal and post natal care, setting up a national technical committee to incorporate newly emerging technologies in neo natal and pre natal care, pursuing compulsory registration of births, providing counselling and advocacy about contraception after the birth of a child, improving capacities at health centres regarding neo natal care, sensitizing health personnel in integrated management of childhood illnesses, ensuring availability of supplies and equipment in maternal health care centers, pursuing vigorously pulse polio campaign and ensuring 100%

routine immunization for all vaccination preventable diseases, promotional and motivational measures in couples below poverty line for late birth of the first child and proper spacing of the second, formulating special schemes for vulnerable children, street children and child labour, exploring feasibility of national health insurance scheme, expanding ICDS programme to include children between 6-9 years; providing vocational training for girls, etc.

Almost all the recommendations listed for child health and survival above are within the range of capabilities of the PRIs to implement. In fact, PRI institutions are better equipped to operationalise these recommendations with adequate assistance and help from institutions of civil society besides co-operation from government institutions. The only recommendations which require an element of additional funding to be taken up relate to special schemes for vulnerable children, feasibility of health insurance, expansion of ICDS programme and provision for vocational training for girls. Of these, there are already existing schemes in respect of vulnerable children although their reach may be limited and for provision of vocational training whose coverage may be narrow. Proactive advocacy measures can also bring some of these schemes to the specific districts/ blocks depending upon their satisfying the eligibility criteria. The rest of the items can in any case be given effect to by appropriate utilization of existing infrastructure and resources and mobilization of resources from the civil society and the community.

The recommendation made by the working group on empowerment of women and children and adolescents largely touch upon the items listed in the national population policy document with greater elucidation. As mentioned in chapter III, the NPP-2000 has fixed a set of 14 national demographic goals to be achieved in each case by 2010. The recommendations of the sub-group on empowerment of women and

children in respect of NPP-2000 have been discussed in chapter III in detail. For population stabilization, the sub group had additionally stressed the following:

1. Identification of areas which would require additional inputs of child and maternal care services to reduce IMR and MMR and introduction of flexible approach with additional Anganwadi centres and supplementary nutrition, where required, for monitoring the performance and improving services in critical areas.

2. Convergence of existing food stock for providing nutritional security, at least to infants and mothers through ICDS centres

3. Extension of ICDS to 450 blocks, which have the highest incidence of infant and maternal mortality. Effective convergence at grass root level between ICDS programme and infrastructure of health and family welfare department.

4. Vigorous implementation of schemes for encouraging compulsory education among girls.

5. Vigorous action for preventing child marriages.

The recommendations made by the group have emphasized strongly that empowerment of women and development of children is the key to stabilization of population.

From the foregoing, it would be clear that except those items of recommendation which are related to policies and therefore, have to be pursued at the level of the State Government / Central Govt., all other recommendations are within the jurisdictional domain of PRIs and have to

be implemented through them. It is to the credit of this sub-group, more than any other, that it has comprehensively outlined the role of Panchayati Raj Institutions in their tasks and has given them a crucial position in implementing many of its recommendations.

This working group not merely agrees with it but also reiterates that Panchayati Raj Institutions alone are in a position to actualize many of these ideas / suggestions. Therefore, the focus of the government departments and agencies should be on how to empower PRIs through devolution of authority and resources on the one hand and capacity building on the other to enable them to do this. This is the thrust of the working group's recommendations not merely in respect of this segment but subjects discussed in other chapters as well.

CHAPTER VI

Capacity Building Of Panchayats

The preceding analysis of the potential role of Panchayat Raj Institutions and the wide range of functions they are expected to discharge in the field of development would envisage considerably empowered institutions in terms of capabilities, knowledge, vigour and dynamism. Most of the elected representatives are in their first tenure, though some may also be in the second term. Also, in large number of States substantial devolution of powers has not taken place. Their activities in such parts have been confined to spending small allocations on rural infrastructure or distribution of subsidized assistance under specific programmes from the funds directly received from the Central/State Governments. Therefore, the role of PRIs in the field of population stabilization as conceptualized in this report can be adequately effectuated when these Institutions are adequately trained to discharge their role.

Capacity Building – The Rationale

The need for Capacity Building of elected institutions is not sufficiently appreciated. This is evident from the insignificant efforts and resources devoted to this work so far. It is therefore important to underline the reasons for taking up this work. The rationale for Capacity Building of PRI functional areas include the following :

- The elected representatives of PRIs particularly at lower levels and more specifically women are new entrants who are probably participating in electoral politics for the first time. Most of them may not have had experience of participating in public life or party

politics earlier. Obviously, such people are not likely to have occupied any position which involved taking decisions, designing programmes or monitoring and supervising delivery of services. Therefore, these functionaries would have no clear vision of their role and its evolving nature. It is necessary that they be trained to develop potential as well as appreciate limits of their position to enable them to discharge their functions properly.

- It is important for PRI functionaries to realise that powers conferred on them through these elected positions are to be exercised within a set framework. This framework has been carved out through a variety of rules, regulations and processes which are both enabling as well as constraining. In their decision-making and interactions these limits have to be recognized so that unnecessary frictions are avoided. At the same time it has to be recognized that rules and regulations need to be simplified to facilitate smoother functioning of the PRIs.

- Various field studies indicate that PRIs display a very narrow perspective of their role in development activities. This could be largely because of the conditionalities imposed by State agencies while releasing funds to PRIs. The approach of PRIs may become different if they are allowed freedom of action. However, at present, it is usually their perception that they discharge their role and satisfy their constituents better if they are able to create/provide physical infrastructure to their area such as a road, a bridge, a building, a public facility, a bus stop etc., in other words, a perception of 'construction oriented development'. Most PRI functionaries also construe their powers in terms of the extent to which they spend public resources - higher the expenditure, the greater satisfaction

they claim in terms of development of their area. The other consideration, which guides their thought process and behaviour, is how far they can distribute patronage to individuals/ groups in their constituencies. This helps them to build up a patron-client relationship. If the potential of PRIs as envisioned in this report has to be realized, this perception needs to undergo a radical change. The capacity Building Programme has to convey in forceful terms that PRIs can achieve greater satisfaction for their constituents by interventions in programmes of social sector, such as health, education, sanitation and environmental improvement most of which may not involve setting up any visible infrastructure, additional facility or entailing any expenditure but by simply enabling people to access services, bringing service providers in direct and easy contact with beneficiaries, or through information dissemination which helps people improve their quality of life. Focus on such programmes can earn considerable gratitude of their voters. Therefore, even politically such programmes are paying.

- A plethora of programmes in different sectors of development are getting implemented throughout the country. Most of these programmes would now fall within the domain of PRIs. These programmes cover a large number of subjects. PRI functionaries are not conversant with the complexities of the subjects these programmes cover. Even officers and professionals take time to acquire knowledge of different programmes with which they are not familiar. The problem would obviously be greater with PRI functionaries. The Capacity Building Programme should focus on conveying essential knowledge about them so that they can take informed decisions, are not misled by officials and can make meaningful interventions in the interest of people. Besides, this

knowledge would also be essential for PRI functionaries to convey messages contained in these programmes to people in simple language intelligible to them, which government functionaries are unable to do. The situation would improve as decentralized planning strikes firm roots in the coming years and eventually bottom up approach to participatory planning and development becomes a reality.

- Development activity of any type has the potential of generating conflict as it may benefit some and possibly hurt others. Similarly, peoples' mobilisation for special goals may also bring PRI functionaries into conflict with vested interests or specific segments of society. Political processes themselves give rise to a lot of conflicts, as competitive demands on resources and power do not lend themselves to easy resolution. The Capacity Building Programme should incorporate within its ambit mechanisms for conflict management within the overall perspective of equitable social and economic development.

- While PRIs ostensively have to administer public sector programmes, activities, institutions and resources, non-government institutions may also be operating specific programmes in their jurisdiction, either funded by govt. or through resources mobilised from outside including international donor agencies. Besides, in service sectors such as health, education, welfare, private individuals and trusts also run institutions and provide services. Sometimes, the public and private sectors both may be catering to the services in the same sub sector or facility. As usually happens, these services have no direct linkage with govt. and govt. also has no leverage with and control over them. Nevertheless, these institutions represent additionality of

monetary, material and manpower resources in the area and bridge some gaps in availability of services. PRIs need to be trained to seek cooperation from these agencies in order to enlarge the gamut of benefits to the people in their jurisdiction. This cooperation can help both and would considerably benefit the people. This public-private partnership/cooperation should constitute a promising area of Capacity Building where initiative and innovation would be immensely rewarding. This has so far been an unexplored area.

- Capacity Building should not be considered as a general training course to introduce Govt. programmes. It is intended to be a serious effort at laying foundation of democratic governance. This underlines the need for a comprehensive design of the training curricula and attendant approaches for imparting it. The contours of such a design have been captured in the following broad themes :

- Sensitisation about their role in social development. The members of PRIs would have to be given comprehensive exposure to what all they can achieve with their present status and with the enhanced powers and resources they are likely to get in the long run. They would have to be oriented a great deal towards social sector activities - education, health, drinking water, social welfare, sanitation and poverty alleviation programmes, etc. A paradigm shift would be required in their thinking i.e., from attaching importance to expenditure oriented or subsidy distribution activities to stressing those programmes that deliver services and create facilities without incurring much expenditure. Some examples are: to ensure that ANM from the health sub-centre reaches the village and as per programme provides necessary

ante-natal and post natal services to pregnant women, to administer child nutrition programmes, to persuade families to send their children particularly the girl child to school, to disseminate knowledge to village men & women about personal hygiene, clean environment and sanitation. The sensitization programme should include those areas where by creating enabling conditions people are helped to access existing services which do not reach them despite their entitlement through awareness generation, counselling information sharing, promoting linkages between service providers/ institutions and individuals seeking them. There are many activities where no product is delivered or a patronage is conferred but necessary facilitation is promoted for people to derive benefits of the programme. For example, presently people affected by communicable diseases such as leprosy, TB, Malaria are unable to access medical advice and treatment even though they are entitled to it free of cost. If Panchayat in its jurisdiction facilitates contact between service provider and patient, enormous benefit would accrue to the patients suffering from these diseases. The beneficiaries of such effort would be ever grateful for facilitating their treatment. In short, the PRIs have to be oriented to a conceptualization of their role where such facilitation holds the key to entitlements rather than in delivery of a product or setting up a facility. This conceptualization is under emphasized if not neglected altogether, which is the reason why Panchayats even with admittedly inadequate empowerment do not tap their existing potential.

- Panchayat Raj institutions need to be conveyed in very strong

terms that considerable space is available for them to act in the area of empowerment of people through information sharing. Social mobilization can be attempted through information, education and communication. This would help people to protect themselves from exploitation by forces within the government and outside, and exert pressure on officials and institutions which are mandated to deliver specified services to be responsive to their needs and change their orientation of work and behaviour. The area of IEC is indeed very large, ranging from information about preventive aspects of public health, specific information on a service that can be availed of and how (such as treatment of serious diseases), skill development opportunities, availability of Welfare Services, linkage between nutrition and health, how personal hygiene and environmental sanitation around the habitation can be organized, benefits accruing from education and equal affection and care of the girl child, risks of employing child labour, diseases associated with certain occupations, how drinking water can be purified and public drinking water source could be protected, precautions which a birth attendant must take when attending a delivery case, most locally available flora and herbs which can be used to alleviate suffering in the absence of a Doctor etc. The list can be expanded not only to cover development programmes but also social justice measures.

- Knowledge brings power. PRIs need to know what they can do in specific development Programmes falling in their jurisdictional domain. These Programmes are presently being implemented with a set of guidelines which lay down that

public functionaries dealing with them would provide necessary benefits/services to the people. PRIs should be familiarized with programme guidelines to know exactly whom they should contact and who would intervene in respect of each scheme in the overall interest of the people. In the absence of the detailed knowledge of the schemes, PRI functionaries may either refrain from taking any interest or may make inappropriate interventions, which may create friction with the service providers or implementing officials. Exercising their authority and making interventions based on knowledge and understanding would strengthen their position and empower them to discharge their role effectively as the link between people and Programmes. To take an example, under ICDS Programme dry or cooked food is provided to infants and lactating mothers at the Anganwadi Centres. PRI should know the scale of such supplies and services to be provided by Anganwadi workers at the Centre. Further, if there is a programme for providing food security, Panchyats should identify starvation prone areas, get schemes prepared and sanctioned for starting public works programme for the able bodied and providing gratuitous relief to the indigent persons. Panchayats can also quickly mobilise local measures to start a grain bank to prevent starvation. It should keep an eye on the PDS system and ensure that gram sabha approves names of genuinely BPL families for receipt of subsidized food grains. It should watch the conduct of PDS shop keeper and local moneylenders on such occasions. The areas of role articulation can get enlarged considerably, once PRI functionaries realize the potential benefit they can deliver.

- PRI have two types of powers in the field of development; one relates to implementation of certain programmes already drawn up at higher levels; the other to plan new programmes based on the funds allocated or mobilised by them. The second role is more complex as it would require planning skills. The designing of new programmes would envisage capability to correctly assess the local needs, available resources and those which can be locally mobilised, identifying components and institutional arrangements to be incorporated in the structure of the programme and a clear vision of how the programme would proceed towards goals set for it. It would also require an understanding of what kind of linkages would be necessary with authorities, institutions and programmes outside the control of the PRIs and how these linkages can be fostered and promoted. These programmes would cover a wide gamut of activities ranging from creation of infrastructure to setting up facilities and arranging for services. This would call for communication skills on the part of trainers to sustain their interest and motivation and to enable them to appreciate how this knowledge can be profitably used to effectively discharge their functions and to raise their stock with people. For example, PRIs want to ensure that in remote and inaccessible areas, services should be available to reduce IMR/ MMR and mortality due to epidemics but the nearest public health facility is far away with no road communication and the doctors/ para medics do not visit the village on scheduled days as specified. PRIs in such a situation can take a number of steps such as to sanction construction of at least a kuchcha road linking the village with the nearest road leading to a health facility under the Rural Development

Programmes. If public funds are not readily available for this purpose, private local funds may be mobilised with cooperation from the villages which would benefit from this facility. The Panchayat can also have pressure brought upon the rural development functionaries and higher level PRIs to allocate resources for this purpose.

- In the context of the tasks allotted and the departments transferred to the PRIs, a large number of public functionaries would be working under the direct supervision and management of Panchayati Raj institutions. While these functionaries have been in contact with PRI functionaries from before, with the 73rd amendment of the constitution and the enactment of state law conforming to it, the control over their functionaries has to eventually get transferred to the appropriate level of PRIs. While most state governments have not yet taken this step, even in its absence, PRIs would still be in a position to exercise a lot of authority by virtue of their democratic status and statutory position to get their directions enforced and to make these functionaries responsive to the needs of the people. The PRIs would, in any case, have the status to seek answers from them in respect of the powers they exercise and funds they spend. Public functionaries cannot afford to ignore them because they can raise a lot of hue and cry against their conduct and mobilise people against them. The administrative control that PRIs will be required to exercise over the public functionaries is a major area of management skills which the PRIs should be trained to learn. Incidentally, this is also one of the most sensitive and tricky areas because it is likely to bring PRI functionaries into conflict

with public functionaries. It is, therefore, all the more important that requisite understanding and sensitivity in the elected representatives of PRIs while dealing with public functionaries is emphasised. But, public functionaries also have a responsibility to discharge, e.g. to translate into programmes & schemes the ideas and proposals conveyed by office bearers of PRIs. Thus a great deal of cooperation would be required between the two. How this cooperation can be promoted without sacrificing the supervisory role of PRI representatives should be one of the thrust areas of capacity building. For example, while persons exercising authority in PRIs need not behave rudely with service providers in public, they should continue to take them to task for neglecting their work, not providing services as scheduled, keeping premises untidy, behaving arrogantly with people and similar other such derelictions of duty.

- One of the major objectives of decentralized development lies in the expectation that these institutions would mobilise local resources for an existing or a new programme and for which requisite resources are not available or forthcoming either from the Government or non-governmental sources. These resources may be in the form of monetary contribution, material or manpower without seeking any remuneration. It may include voluntary efforts for carrying out social audit of various programmes and technical inputs for implementing certain programmes. Also, the PRIs have the advantage of deciding on a differential or voluntary system of mobilisation of such resources depending upon the status and the income potential of constituents. The capacity building programme

would train PRI functionaries in methods and processes by which such mobilization of local resources can be effected without any coercion, strain or caste bias.

One of the functions, which PRIs can discharge straightaway without any devolution of powers and resources from the State Govt., is to carry out an impact evaluation or social audit of programmes already in operation in their area. For this purpose, PRI bodies would be required to constitute groups of persons who enjoy impeccable reputation for their integrity and objectivity to investigate whether specified development programmes have achieved their objectives and whether the funds allocated for them have been properly spent, whether guidelines for the programme have been adhered to, whether the programme has benefited the people or the group whom it had intended to do and whether the implementation of the programme was constrained by delay, interference from unauthorized quarters and whether different levels of public bureaucracy had exercised their mandated role in its planning, implementation and supervision. This work would enhance the prestige and standing of Panchayat Raj institutions and would bring them closer to the people. Such initiatives would also create adequate pressure on the public bureaucracy to desist from ignoring the programme objectives, guidelines and procedures and also to be responsive to the interventions made by PRI functionaries. The capacity building programme has to empower the PRIs with knowledge and information on the mechanism of getting such social audits carried out and how those entrusted with carrying out such social audit could obtain the correct information on the schemes from available

records/ documents, gathering feedback from people through field visits and how they could be vigilant of attempts to mislead them by interested persons. This exposure would also enable Panchayat Raj representatives to understand the functioning of governmental organizations/complexity of decision-making processes and would help them in effecting improvements in the execution of future programmes.

- One of the greatest advantages of decentralised development is that it can actualise the process of convergence of inter connected programmes but administered by different government organizations in a given area and achieve the desired objectives covered by such programmes. The 'convergence' of allied programmes for achieving requisite impact is now a well-accepted objective of development planning, though rarely realised at the ground level. One of the reasons is the tendency in public representatives to exert pressure that every programme should be taken up in all constituencies even if such fragmentation yields little tangible benefit anywhere or to locate programmes in areas not warranted by objective consideration of their optimal utility. On the other hand, a certain degree of trade off between different programmes in different constituencies can lead to more efficient utilisation of resources and more effective benefits to people over a period of time. The advantages of convergence would need to be effectively conveyed to convince them of its overall usefulness. They could also be trained on how such convergence could be carried out and equitably spread to different areas with appropriate trade off through political negotiations. A striking example of achieving

such convergence would be to improve drinking water facilities in habitations perennially affected by water borne public health disorders. The convergence would also create visible impact where attending to pre natal and post natal checking of pregnant women and training of birth attendant for safe delivery practices is specifically focused on areas with higher IMR/MMR. Once benefits accruing from such convergence gets demonstrated, it would be easier to convince eligible couples about a small family norm. Similar convergence in respect of other development areas can also be promoted.

- A neglected area of public administration is how resources in private sector for development can be harnessed. Panchayati Raj institutions need to learn how to tap this source for funds and material support. While PRIs would have powers and resources to deal with public sector programmes and manage public sector institutions, the network of non-governmental organizations and private sector providers of services remain outside their area of scrutiny and intervention. For example, it is well documented that private medical practitioners and institutions provide a substantial part of health care to people including very poor people. This may be on account of easy access, better behaviour of service providers, higher quality of service or lack of an alternative etc. PRIs could coordinate with service providers/ Institutions in Private/NGO sectors and seek their cooperation in implementing various programmes of health and family welfare including Disease Control Programmes. Public-private Cooperation would have the advantage of enlarging the resource base available to the people in their area, enable the government aided programmes

to reach a larger mass of people including those who for various reasons do not have access to public sector institutions. Panchayati Raj institutions could also utilize the services of private medical practitioners, particularly specialists in private/ non-governmental sector hospitals to render services in public health facilities on mutually acceptable terms and thereby enhance the utility and serviceability of public health institutions themselves. This would be true of some other development sectors as well. The Capacity Building Programme should help PRIs identify areas of such cooperation and mechanisms of effecting them in the larger interest of people in their jurisdiction.

- The position with regard to NGOs is similar. A large number of non-governmental organizations operate in various fields of development such as health, education, poverty alleviation and income generation, social welfare, housing, sanitation, environmental improvement, social defence. All these subjects are also handled by govt. through a large number of schemes and programmes. NGOs are credited with more people friendly approaches in reaching their services, more sympathetic understanding of their social and economic conditions and providing necessary interventions in time of need promptly and without harassment. These advantages bring NGOs much closer to their target groups when compared to Government functionaries of any department. Therefore, by enlisting their cooperation and appropriately integrating their work harmoniously with the work of development programmes under the Government, the resource base-manpower, material and monetary-available to the PRIs gets enlarged and

capability to effectively reach their services to the people increased. The capacity building programme for PRIs would have to focus attention on how this resource base can be harnessed without creating any conflicts and distortions. The task is not very easy as there is an under- current of tension between the PRIs and the NGOs with both having stereotype perceptions of each other. Similarly, Government agencies whether bureaucratic or non-official are hesitant to seek help of private service providers in Government programmes. But this traditional approach is changing and there are instances where creative initiatives of cooperation between the two have produced good results. The capacity building programme has to bring out this potential to convince PRIs about the gains from this cooperation in terms of coverage, effectiveness and quality of service. Health & FW is a very promising sector for private-public cooperation. Poor people accessing private/ NGOs service providers can be linked to govt. health facilities for drugs and other services, which are given free. In TB control programme in Hyderabad, this has been tried with good results#. Similarly, private sector hospitals/ NGOs can help Govt. by providing services of their specialists, particularly Gynecologists for attending to serious cases of delivery or infant/ child health in PHCs / CHCs where no such medical personnel are available or willing to work. Even part-time and periodical fixed days visits would improve RCH services and provide immense relief to patients.

Panchayati Raj Institutions in their constitutional incarnation have been in existence for close to a decade. In some states, they are in their second tenure of five-year period after the

#Malcolm Harper, Public Services through Private Enterprise (2000)

73rd amendment followed by the corresponding state law while in others they are still in their first tenure. Even during this limited period their experience of dealing with various institutions of the Government and public functionaries has been constrained by the lack of adequate powers and resources placed at their disposal. At the lower rung, entrants to these institutions are new comers with no previous experience either of politics or administration. Their exposure to the functioning of Government offices is virtually negligible. Being unfamiliar with the manner and processes of functioning of Government offices, they are equally non conversant with rules and regulations which guide the government functionaries in discharging their duties. They also lack understanding of the relationship between different levels of Government institutions. In this background, after assumption of power, when these representatives deal with public functionaries for the first time, they are impatient and there is an under current of tension which creates a lot of friction between elected representatives and their bureaucratic instruments. This affects the smooth functioning of PRIs as well as the delivery of service to the people. The capacity building programme for PRIs should therefore provide a great deal of exposure about the functioning of Government and its offices at various levels. This is necessary for the elected representatives to appreciate the constraints within which public bureaucracy functions and the work culture which binds them so that they do not place undue demands on them. Simultaneously, there is also need to combine it with the reorientation of public functionaries so that

they appreciate the imperatives of decentralisation and democratic governance at the local level. This is the most important aspect of capacity building training because harmonious functioning of the two institutions is absolutely necessary. In the area of Health & FW, for example, one of the reasons why ANMs do not stay in the villages is that there is no official accommodation available and there are security considerations as well. The local village Panchayat can persuade the concerned villages to provide a separate living room to the ANM and additional space that can also serve as her office. The residents of the villages should also ensure her security and render help to her in transporting drugs and other health material connected wither work from the office of the Issuing authority. In some inaccessible areas, doctors and para medical staffs do not visit villages because there is no road and therefore, no public transport is available for commuting the distance. The local PRI can mobilise funds for creating road connectivity. Until such time as a road is constructed, the PRI can locate a point which is connected to an existing serviceable road where people can gather on a specified day and time and ensure that the concerned health staff visits them. Block/District Panchayats may also be approached to arrange training for Local youth (at least one male/ one female) as health workers who can carry out the directions of the health staff and to provide first aid in the absence of the health staff.

- Local self-governance implies a certain degree of self-reliance. PRIs should be able to carve out a space for certain activities where they need not depend upon resources from Govt. but undertake to mobilise local resources - monetary, manpower

and material from people. The larger the space they create for mobilizing private resources wider would be the reach of the PRIs and greater would be the satisfaction level of the people. While PRIs should definitely access maximum resources possible under various programmes for their area, they should take initiative to go in for voluntary funding from the public, where feasible, and even take up programmes which do not require monetary input but other means of cooperation such as labour/material contribution so that public needs can be met expeditiously. The capacity building programme should cover both aspects, i.e., advocacy for larger allocations from funding organizations of Govt. as well as innovative ways of harnessing private local resources, both monetary and non-monetary. Cleaning of drinking water sources, undertaking wastewater disposal, environmental improvement around habitat, renovation of common facilities are some of the programmes which can be entirely attended to by voluntary labour without waiting for Govt. funds to be allocated. Similarly, IEC programmes on Health, social welfare, income generation, etc. can be launched through human resource mobilization without any monetary payment but with due social recognition to the efforts made by concerned persons.

- Health is a very important sector of development where peoples' access to services is acutely constrained, among others, by the different hierarchies of programmes. The village Panchayat has in its jurisdiction health delivery institutions such as sub-centres, Primary Health Centres (PHCs), and workers of family welfare programmes. The block

panchayat has under it community health centres (CHCs) while the sub-divisional and district hospitals fall in the domain of the district panchayat. Various disease control/public health programmes/Family Welfare Programmes have their separate workers. For example, the Leprosy Control Programme, TB Control Programme, Blindness control programme, RCH Programme, Malaria Control Programme are implemented by their respective health workers whose jurisdictions are not co-terminous. Their vertical hierarchies are carved out as per needs of the concerned programme. Most of these programmes are operated through bureaucratic formations and do not involve Panchayati Raj Institutions even though health falls in the jurisdiction of PRIs. Worse still, these programmes also do not operate [barring RCH and in some respects HIV-AIDS] through local PHCs/CHCs/District hospitals. This is the greatest constraint in accessing services by the needy patients. The focus of capacity building programme for the PRIs in this sector should be on ways in which horizontal linkages with public health Institutions can be promoted so that the beneficiaries can easily access treatment facilities. This would go a long way in improving the reach of the programmes to the beneficiaries. The PRIs can provide the much needed public participation to these vertical programmes and rationalise their linkages so that the need for supervision and control by higher level medical professionals/para medical workers is considerably reduced and at the same time the quality and timely delivery of service is not adversely affected. A striking illustration in this context is the DOTS strategy for TB control programme in which the medicine has to be administrated to the patient under the direct supervision of a

health worker. Surely, this linkage can be provided by the local PRI through a specified member to obviate the need for a health worker to be present. This would improve the rate of dropouts in the programme due to hassles in obtaining medicine and increase coverage as well as optimize cure rate.

The above is only an illustrative and not an exhaustive list of contents to be covered. The dimensions of capacity building thus outlined point towards an enormous task to be accomplished both in terms of number of people to be trained as well as the comprehensive nature of contents to be dealt with. Naturally, therefore, considerable prior preparation and great deal of consultation with experts would be necessary before evolving a suitable course design, methodology of training and mechanism for covering such a large number of functionaries can be covered. The following steps are suggested for taking up this task :

- Preparing a conceptual document on the entire gamut of capacity building comprehensively covering all important aspects.
- Identifying institutions which could be entrusted to carry out capacity building programmes
- Preparing design of training programmes.
- Preparing training literature covering various aspects exhaustively.
- Discussing pedagogic aspects of training with a cross section of people interested in decentralised development including participants themselves and refining the design thereafter.
- Taking up a massive programme of training for trainers.

- Identifying Private Sector institutions, CBOs and NGOs which would supplement training programmes undertaken by Public Sector Institutions with inputs on peoples mobilization, problem solving techniques, conflict management, politics-development interface, etc.
- Resource allocation
- Institutional arrangements for monitoring/gathering of periodical feedback for revising course content, training literature, methodologies of training and strategies of wider coverage
- Periodical impact assessment and social audit of Capacity Building Programme.

These measures would crystalise only if capacity Building Programme for PRIs is systematically pursued. At present, a large number of government agencies and NGOs have been involved in sensitisation, training and capacity building for members of PRIs. Their efforts need to be dovetailed into a comprehensive and coordinated approach to capacity building programme for PRIs. Many NGOs have also received support from donor agencies for such training. For PRIs to play a greater role in population stabilization throughout the country with equal seriousness, there is need to initiate a regular scheme.

CHAPTER VII

Role of Self-Help Groups in Population Stabilization

Since 1990s NGOs have experimented with an innovative approach to rural development by organizing/promoting informal groups of poor, especially women in rural areas for self-help/mutual help. This movement has picked up so fast that today self-help groups have emerged as an alternative mode for credit delivery to the rural poor. The genesis of self-help groups lies in the inability of the formal banking sector to cater to the needs of poor rural clientale. The banking sector has largely concentrated on financing for productive activities which inevitably serve the segments of rural population that have income generating assets such as land. The large majority of the rural poor are landless and need credit for financing income – consumption gap or meeting occasional crisis and emergency situations. There is a mismatch between the credit delivery system and the needs of the poor which makes them dependent on informal credit sources like moneylenders, contractors, traders etc. Hence the emergence of self-help groups to bridge the gap between demand and supply of credit for this segment of rural population. The self-help groups have also emerged as the forum where poorer and marginalized sections that are bypassed by the development process find some space available for speaking out, articulating their needs and determining the direction and pace of their actions and activities. Thus, self-help groups are also grass root level participatory institutions of the poor for their own development albeit in limited areas of income generation and social development besides accessing credit input. In this process, they are helped through stimulation from outside by non-governmental organizations. As the village society is not homogenous and is fragmented into various caste and occupation categories, this mode of mobilization also

serves another purpose, i.e., to organize around a common set of goals, sharing the broadly similar kind of social and economic base and not inhibited by any cultural constraints towards participation. The size of the groups serves the purpose of most intimate interface with one and another among the members which is so very important for persons from marginalized sections particularly women. As a group it enables them to come face to face with those in authority and power without being overawed by their status and to access services and benefits, which would have been difficult to do as an individual. In the context of the widely prevalent gender discrimination in all facets of life regardless of caste, class, status and, in particular, poor access to credit for women in the informal sector and even more so for women headed households, self-help groups have evolved mechanisms for bridging gender inequity and as forums where women can speak up and take command of the situation.

The experiment of Gramin Bank in Bangladesh and now sufficient experience available in India in respect of credit delivery through group lending has re-established bankability of the poor women and reduced their dependence on informal lenders. It has also shown that even illiterate and socially deprived women have potential of management since such self-help groups have also performed well in the matter of recovery of loans through peer group pressure, mobilization of local resources particularly non-monetary and of conflict resolution. While these qualities of leadership, participation, management and direction have largely been tested in the field of savings and credit delivery, the self-help groups have by no means confined themselves only to these limited activities. They have taken up not only economic activities for income generation in agriculture, manufacturing and service segments but have also used their meetings for discussion on social problems which afflict them, be it alcohol consumption of their husbands, social treatment within the family, health related

problems, problems relating to drinking water, fuel and fodder etc. It is true that the activities under the latter category have not yet emerged as prime movers for these groups on a large scale but have been usually ancillary to the primary activity of management of savings and credit.

It is in this context that self-help groups present a highly potential area for their effective utilization for the purposes of population stablisation. This is because of the following reasons:

- As formation of self-groups have become an integral part of the strategy adopted by government to deliver various benefits and services under poverty alleviation programmes, more specifically those relating to income generation, to the target groups and are also sanctified by donor agencies in their projects on social development by virtue of their participatory orientation, a huge space is available where at least health related problems pertaining to maternal and child health/reproductive and child health can be discussed in these groups without inhibition. This forum, therefore, can be effectively utilized to mobilise support of women for various health related programmes, not necessarily confined to RCH/MCH matters. This in turn will help members of these groups acquire necessary knowledge about their own bodies and more specifically its reproductive aspects as also about various devices available to control fertility within the constraints of their social situation.

- Self-help groups can also function as informal NGOs for specific health and family welfare activities such as dissemination of vital information on maternal and child health, contraceptive devices, personal hygiene etc. not only for their members but also for others who come in contact with them. The range of information

dissemination can be extended to issues related to public health, nutrition, availability of services for termination of pregnancy etc. Self-help groups can also become agents of social marketing for contraceptive devices, where they can present their own experiences as a mechanism for convincing others coming in contact with them. These self-help groups can also be used for delivery of 'safety kits' used at the time of delivery, keeping information on births, deaths, pregnancies and marriages and specifically for preventing female foeticide/ infanticide.

- Health service providers in the public health delivery system can make use of these self-help groups for getting feed-back on certain crucial programmes such as immunization coverage, ante-natal, post natal check-up, ICDS programme, schemes relating to empowerment of girl child and adolescent girls or any other programmes where such feedback is of a crucial help in improving the delivery system and targeting specified individuals, groups, categories.

- Self-help groups have a great potential for building up confidence among women members (similar possibility exists for men in their groups) to assert and take measures for reducing family size in the face of non-cooperation from husbands/in-laws/other relatives. A small success experienced by a member in the process of self-assertion by skillful negotiation against such odds may boost up the morale of remaining members considerably, which no degree of counselling by public bureaucracy can match.

- Self-help groups can serve as an important conduit for countering disinformation on impact of various contraceptive devices on user's health and reproductive potential. The countering of such

disinformation would not only be authentic and effective when a women relates her own experience to another women member but also when experience is shared in respect of her husband or by a husband in respect of his wife. Other women can convince their husbands about the use of contraceptive devices/fertility control mechanisms by relating experiences of fellow women and their husbands.

- Women members of self-help groups borrowing from pooled fund for health related needs can be brought in contact with service providers in public health care institutions to reduce their need for borrowing on this account and to help get services in public health centers free of cost. This would save a valuable part of their meagre earnings now spent on health in the private domain which would make it possible to use it for improving intake of food and nutritional diet and meet other vital needs.

- Self-help groups, even if their activities are at present focussed on credit delivery, can, in addition, take up activities on sanitation, functional literacy, skill development for income generation, management of assets, environmental improvement, social forestry for fuel and fodder etc. The widening of the area of activities would strengthen their bonds and the effectiveness of the group.

- Self-help groups can be effectively used with appropriate training for early detection of communicable diseases such as TB, Leprosy, STD, as also early signs of various forms of disability. This will enable affected individuals to seek expert medical attention in time so as to obtain curative treatment in respect of communicable diseases and reduce adverse effects in respect of others, which may prevent

disabilities. It will also help propagate preventive measures for such afflictions since inevitably individual experiences would be discussed in group meetings.

- Self-help groups can be used for gathering early signals/warning about epidemics, pubic health related problems such as diahorrea, cholera, conjunctivitis, gastroenteritis, food poisoning etc. and to convey messages related to preventive measures as well as elementary practices to act as first aid before medical aid becomes available. This would reduce the load of grass root level health service providers and improve their own system of information gathering. The awareness generated by self-help groups would also put demands/pressures on PRIs/public bureaucracy to rush necessary medical help to control such epidemics or medical emergencies.

- Self-help groups can also be used for collecting information on psychological and behavioural health problems, which are usually ignored due to lack of knowledge of their impact and availability of cure in respect of them. This information would be a valuable tool for health authorities to equip their health care centers with necessary infrastructure and training of staff to tackle them at the early stages. A massive information campaign can also be mounted to generate correct appreciation about such problems and approaches to deal with them within the family.

- Self-help groups are also the best means for determining who among the members of their community are the most needy beneficiaries of any programmes particularly those of poverty alleviation which require rigorous targeting and prioritization. This could be cross

checked with feedback emerging from various official and semi-official sources which would help in corroborating/discarding information concerning persons so identified and would thus generate greater public confidence in the efforts of implementing authorities to correctly target their alleviating measures. This would be particularly valuable in beneficiary oriented development programmes where under various pressures the most needy and eligible do not get identified and the ineligible persons corner the benefits. The correct targeting resulting from such efforts can have great motivational appeal for pursuing family welfare programmes.

- Self-help groups can also be utilized by service providers in development programmes for operationalising schemes relating to care, treatment and consideration of the girl child, assisting families in accessing them for the benefit of the girl child and for gathering information on the impact of these measures on the status of the girl child. Their assistance can be taken in targeting families for corrective intervention where girl child is neglected.

- Self-help groups would be effective instruments for carrying out social audit in respect of development programmes, implementation of regulatory measures and social welfare laws particularly where women are the targeted beneficiaries or where programmes impact women in a major way favourably or otherwise. This would have the effect of empowering the groups on one hand and generating consciousness among women on the other. Programmes such as National Maternity Benefit Scheme, National Social Assistance Programme, National Family Benefit Scheme, Indira Awas Yojana, income generating programmes for women, etc., could be taken up for social audit as a lot of complaints are usually received about their

implementation. Also, specific role could be assigned to SHGs in respect of implementation of laws against foeticide, infanticide, enforcement of laws relating to restraint of Child Marriage and prohibition regarding Pre-Natal Diagnostic Techniques.

- Self-help groups can provide voice and strength to the poor through appropriate mobilization and support in the deliberations of the Gram Sabhas where issues concerning them are discussed. They can help articulate their problems and predicaments where individual members of the Gram Sabha feel hesitant to speak or cannot coherently put forward their view point through appropriate confidence building efforts, advocacy and mobilizing outside support.

Self-help groups have sprung up in large numbers all over the country, (in fact, this process is happening across the globe) though the poorer and backward States in the country have yet to witness the emergence of a vibrant self-help movement. Therefore, Panchayati Raj Institutions, particularly at the village level, have before them readily available instruments for use. PRIs also acquire the facility of easy communicability with the larger segment of population, i.e. women through these groups which otherwise poses a great challenge. The field of population stablisation envisages multi-faceted action for influencing the behaviour of targeted population towards a small family norm. This particular activity is amenable to skillful, sensitive and friendly counselling by self-help groups. The group members can manage this task in an unobtrusive manner while respecting the dignity and human rights of the fellow women which official service providers are ill equipped to handle. The groups can also supplement and complement efforts of official health workers so as to achieve better impact of the services they provide. Above all, these groups have the potential of helping the Panchayats in effective utilization of available facilities, resources

and services and thereby helping Panchayats to enforce social accountability in respect of them.

While the huge potential that exists for the self-help groups has been outlined above, this cannot be realized without concerted efforts being put in to build up requisite capacity of these groups to discharge the onerous responsibility. This capacity can be built up through training, institutionalization of their role and carefully worked out confidence enhancing measures. A comprehensive programme needs to be launched for this purpose, which would also provide lessons in conflict resolution and management and particularly in withstanding pressures and divisive tendencies generated from within or outside. Various activities for which a role is being crafted for self-help groups fall in the domain of Panchayati Raj Institutions, largely at the lowest tier. Therefore, it is necessary that the self-help groups are appropriately linked to and integrated with the local Panchayati Raj bodies so that they work as instruments of such PRIs and help them discharge their mandated functions. Also, the PRIs can effectively off-load some of their responsibility to the self-help groups through an appropriate division of labour. In fact, self-help groups provide a ready instrument of mobilization of people to the local Panchayati Raj body within its jurisdiction to which specific tasks can be assigned on a continuing basis. In this process both the PRIs and the self-help groups would get empowered. The friction and tension resulting from their relationship in this regard would throw up interesting possibilities for reassessing strategies of interventions in respect of the Programme.

As the members of self-help groups are ordinary housewives largely illiterate and suffering from crippling constraints, (primarily talking of SHGs for women – there are and can be SHGs for men as well), the capacity building has to be properly designed and its methodology and canvass

evolved after considerable discussion and experimentation. Obviously, health and family welfare and other social development related activities having a bearing on population stabilization would constitute an important component of their course design. Developing communication strategies for such a programme would indeed be a challenge considering that membership of these groups would be diverse in different places.

While knowledge is power and it would be more so for the information starved women of these self-help groups, there would be greater need for generating processes which help in shedding inhibition, encourage self-articulation and assertion, embolden them for questioning the existing power structure in the family and the society constraining their development and promote building up confidence in their ability to shape their own lives and future.

As the most enduring impact of capacity building would be to enhance their self esteem through recognition of their importance and acceptance of their vital role in development, this can be strengthened by publicly acknowledging whenever good work is done by groups or rewarding them by way of additional development resources or/and crucial public convenience/facility to the areas where they have registered significant success. This would motivate other groups to emulate them.

Self-help groups have to be so oriented that they do not depend upon government or other institutions for help in carrying out their activities, particularly where monetary inputs are not involved. The objective is to generate some degree of self-reliance which would have its impact on the community itself. In any case, greater success of the role of SHGs depends upon their native talent for inter-personal communication, negotiating ability for self-assertion, social mobilization and leaderships articulation. Here

innovative methods and context specific strategies are key to success. This constitutes the fitting theme of human resource development.

A large number of activities for which the utilization of the self-help groups has been suggested may bring them in conflict with existing institutions or even the local power structure. This is because the self-help groups have no established or official status. They are not an off shoot of any legal/ regulatory structure or officially sanctioned institutional arrangement. These conflicts may either be horizontal in nature i.e. between members of the group based on caste and class groupings or vertical conflicts with the local power structures or institutions, including PRIs, bureaucracy and even NGO. There is nothing unusual about it. Such conflicts are the essence of development. Neither the groups nor their promoters need shy away from them. In fact as self-help groups of credit delivery, their members may have already experienced such conflicts and may have also evolved mechanisms for resolving them in their own way. The process of conflict resolution may now get extended to a larger canvas of activities i.e., relating to health, family welfare, rural development, sanitation, environment, income generation, social practices etc. The capacity building programme for SHGs has therefore to help them identify possible areas of conflicts and manner of their management in pursuing tasks of population stablisation. Development Sociologists should take up research in respect of SHGs so as to increase knowledge about their strengths and constraints.

While referring to the capacity building it is necessary to point out that self-help groups owe a great deal of their existence to outside help in initiation and mobilization by the NGOs. In fact, many NGOs continue to guide them from outside for a much longer period even after the self-help groups have acquired some degree of self-confidence in managing their

activities. The assistance of NGOs would be required in a larger measure for carrying out capacity building programme for self-help groups and, in particular, for building processes and modes of interaction between self-help groups and Panchayati Raj Institutions. This is an area yet to be explored because virtually no beginnings have been made. This area is also a complex one and is likely to throw up considerable strain in certain situations but needs to be tried out on a more enduring basis, particularly for specially focused programme of population stablisation.

CHAPTER VIII

Planning process as Empowerment
Future Directions for PRIs

In the preceding sections we have mapped out the potential of Panchayati Raj Institutions in development with specific focus on building up a population stabilization movement. We have also identified facilitation processes through which this role can be translated on the ground and the capacity building these institutions would require for this purpose. We have also highlighted contours of interface between PRIs and peoples' organization such as NGOs, self help groups, (the discourse would apply equally to neighbourhood groups, CBOs) at the grass root level so as to bring out untapped reservoir of talent and motivation waiting to be utilized for mutual benefit as also to further the goals of development and population stabilization. It now remains to be articulated what the future course of direction should be for operationalising the multi faceted role of PRIs. This would appropriately take into account the uneven social situation in terms of empowerment of PRIs in the country, extent of their capacity for social mobilisation, and level of development itself. The strategies for intervention emerging from this direction would respond to area and context specific health & family welfare related problems and various development variables impacting on them.

The thrust area of this direction is to make PRIs a key player - a prime mover so to say in the Population Stabilization Programme and a pivot round which other institutional arrangements will revolve. This would involve two things: a) PRIs particularly at the grass root level triggering processes to intervene in health, family welfare and other development programmes for their better reach to the people and improving quality of their services b)

to sharpen the demand for information and services from the people, more specifically the target groups. This would be done through the mechanism of local level planning for health and family welfare specifically for this purpose and other development sectors to the extent they impinge on them. The planning process would be accomplished through a triangular mode: a) Panchayat itself making self assessment, suitably helped by official & non-official agencies about where they would intervene and how and what resources, governmental & societal they would mobilise for this purpose (b) people driven attempts at identifying problems and suggesting pragmatic solutions within constraints of resources and capabilities. This process would also be appropriately aided and facilitated by technical experts and Non-Governmental organizations (c) Professional initiative in terms of collecting necessary data and preparing information base followed by its analysis for planning purposes and bringing out multi-dimensional linkages of health and family welfare problems. The integration of all three sources of knowledge would form the basis for preparing a health and demographic plan of the Panchayat (lowest tier of PRIs). Obviously, consultation with people at the grass roots, organizations of civil society, private/Non-governmental establishments and other interest groups would be reflected in the document of the Panchayat initiated at (a). The process at (b) would prioritise needs and concerns, sharpen demand for information and services, lay down norms for interface with delivery agencies and thus foster grass root level mobilisation. The element at (c) would provide professional inputs to this process of planning so as to prepare a competent and credible document of reference by officials & non-officials alike and would work as a charter for people of the area in terms of their development thrust in this sector.

The exercise referred to at (a) would involve formulating the objectives of health development and population stabilization - virtually the

rudiments of a health policy statement. This policy statement document may contain the following:

- Health development strategy to be pursued in the area in the context of National/State level policies.
- Priority to be assigned to specific activities of health & population development.
- Areas and extent of intervention within the constraints of its functional limits and available and mobilised resources specifying improvements to be effected in the delivery and quality of health care and family welfare services, making them more user friendly and responsive to peoples' needs.
- Improving sanitation facilities and hygienic conditions both in public places as well as in residential areas.
- Protection of drinking water sources to make them safe for use.
- Information dissemination regarding regulation of fertility and other health related matters.
- Specific steps for reducing mortality and morbidity among infants, younger children and pregnant mothers, including assistance sought from NGOs, and cooperation forged with the private health practitioners.
- Facilitating access to curative facilities for communicable diseases and other serious health disorders.

This however is an illustrative and not a restrictive agenda.

The policy document would specifically highlight how marginalized groups of society would be enabled to receive their due share of benefits. This policy document would be discussed formally in the Gram Sabha and in other fora of civil society, and with NGOs, private sector health care providers and their feedback gathered for effecting improvements in the Policy statement.

Regarding (b) as a step towards building up grass root level planning with initiative coming from people, identification of specific needs in health and family welfare sector, including their prioritization would constitute an important activity. This would no doubt include non-health aspects that impinge upon outcomes of health and family welfare objectives. Gram Sabha would provide a forum for people to meet and discuss this aspect and possible solutions within the constraints of sources allocated by government and those which they can contribute. Functionaries of health and family welfare departments, representatives of voluntary organizations, private medical professionals, self-help groups etc. may be associated with this discussion so as to enhance the quality of discourse, motivate marginalized sections to speak up and enable women related problems to get due coverage. These discussions may be structured in the initial years through preparatory documents. The discussion in the Gram Sabha would most likely focus on, among others, the status of drinking water sources, sanitary latrines, waste disposal, services at the PHC and the sub-centers, the attitude and behaviour of health personnel, functioning of the ICDS programme, access to and coverage of immunization, accessibility to diagnostic and curative services at the health care centers and functionaries dealing with communicable diseases under National Programmes, information relating to family planning services etc.

We now come to (c). Quite independent of the exercises (a) & (b) above, the public health functionaries at the Panchayat level with assistance from Panchayat member specifically assigned health portfolio would collect necessary data, information from various offices / sources which collect, store and transmit such information (This may include primary health centers, Anganwadis, veterinary hospitals, schools, cooperative societies, private practitioners, revenue and forest authorities, Block offices, etc.) about health, births, deaths, patterns and level of morbidity, area specific / group specific diseases, if any, women's reproductive problems, nutrition status of children, health status of Dalits and Tribals, life expectancy, spread of communicable diseases, details about private clinics / hospitals and fees charged by them, patterns of employment and underemployment, educational studies, sanitary conditions, drinking water sources, social practices affecting behaviour of people regarding health and fertility, etc. These are only illustrative and not exhaustive items. The information, if not available through official sources, may be gathered, as far as possible, through unofficial sources so as to provide authentic basis for local level planning. The information would be properly analysed by the local professionals within the framework of local planning concepts and presented to the concerned PRI with suggested action points emerging from them.

With inputs coming from these sources, PRIs, (Health Policy Statement) people themselves (Need articulation and prioritisation) & professionals (authentic information and analytical base) the stage is ready for the preparation of a Health and Population Development Report. This report would also highlight problems in delivery of health and family welfare services and impact of non-health factors on the health related problems. The report would also outline the mechanism for inter sectoral coordination and action. As the report aims at integrated planning, support coming from non-governmental organizations, self-help groups,

community organizations, private sector health establishments etc. and other such institutions of civil society would also be indicated. The resource profile in the report besides mentioning the availability of local resources, would also mention specific projects for which help has been or would be sought from higher level PRI bodies / other government organizations.

The above exercise is neutral to the status of empowerment of PRIs. While there is no dispute that PRIs should be strengthened with adequate devolution of resources, transfer of powers and authority, particularly control over local staff to enable them to discharge their mandated / allotted functions, the progress made in this process has been very slow due to lack of political will reflected in resistance from state level political and bureaucratic power structure. We have at present three categories of states, depending upon the level of devolution of powers & resources effected to PRIs.

(a) Where PRIs have been substantially empowered in the spirit of the constitutional 73rd amendment such as Kerala.

(b) Where sizeable powers & resources have been transferred and there is commitment to enhance this domain such as Madhya Pradesh, Karnataka and West Bengal.

(c) States where only the structures have been created without adequate powers.

The rest of the States can be placed in the last category but the situation is not uniform in respect of them. There is need to develop models of social mobilisation, role articulation and strategic interventions which influence process of population stabilization and more specifically

increase people's access to health, family welfare and related services in these three distinct categories. For this purpose, a paradigm shift is needed in the existing structure of delivery system and its interface with people in general and targeted persons in particular. Development programmes including those relating to health and family welfare have traditionally functioned in an organizational framework where service providers in Government reach the target groups and deliver services. They are also the chief conduits for dissemination of vital information that contributes to improving health and practice small family norm. Barring certain areas where NGOs operate horizontally, structural contours of the programme organizations are essentially vertical and involve a heirarchical relationship between target population and the delivery agencies. It is here that the strategic shift is needed. The changed approach would aim at creating objective conditions in which the target population (for example those needing family welfare services) is enabled to come together and discuss its needs, problems, and predicaments as also its frustrations. Promotion of informal forum of women to start with (these may be self-help groups) needs to be encouraged where health, family welfare and related programmes are discussed as part of an intra- community dialogue on day to day problems of survival and coping mechanisms. This dialogue, would inevitably focus on difficulties in accessing various services / benefits of development programmes, meeting unmet needs besides grappling with sociological factors which inhibit adoption of small family norm. In this process of articulation, complexities of linkages and coordination, among others, would surface. But this social interaction would also throw up ideas on what participants can do on their own in the social domain which influences individual behaviour. **It is by creating an enabling environment, promoting such a dialogue, sensitizing PRI office bearers (particularly women members) about their empowered role and developing norms for accountability of service providers both in Government and**

non- government sector and encouraging self-propelled community action for influencing individual behaviour that a grass root level movement for population stabilization can emerge. It is our conviction that the PRIs even where they have not been empowered to take up development projects, exercise control over public functionaries, remove major inadequacies in functioning of health / FW institutions, can still create the enabling environment for encouraging and promoting intra-community dialogue and enlist the assistance of SHGs and NGOs among other agencies. This would achieve the twin purpose of influencing individual behaviour and generating pressure from below for public institutions to deliver.

The problem of lack of resources and power can also be attacked from another direction - i.e. processes of advocacy and pressure through skillful networking of PRIs and civil society institutions on the district administration engaged in preparing a District level plan as a part of its constitutional obligation. The district organizations sit over substantial resources allocated under different programmes and enjoy considerable delegated powers from the State Government to spend them. They also exercise management control over institutions of service delivery and enjoy regulatory powers besides necessary clout to discipline public functionaries with necessary leverage available to them regarding their deployment, making resources available to them for their work, mediating between them and non-officials in matters of friction and undertaking annual / periodic assessment of their work including investigation into complaints of omission and commission against them.

The Planning process at the District level could provide an arena to PRIs to get support for its projects, assertion of control over the local bureaucrats and making management of service delivery Institutions responsive to peoples' need. The development dimensions of the district

outside the empowered zone of PRIs is to be accomplished through the district level Planning committee provided for under the law. The District Planning committee is required to prepare a district level development plan with the help of the specialized agencies under its jurisdiction. This plan would incorporate necessary inputs of resources, prioritization of projects, mechanism for inter sectoral coordination, patterns of public-private partnership, strategy for mobilizing non-governmental organizations and resources and horizontally bringing in supportive inputs from sectoral organizations in the field of education, agriculture, industry etc. which have a field presence and are in touch with people. This plan is expected to lay down (if it is not happening, it should be so mandated through executive order) the sequence of activities, specify the role of each agency and outline mechanisms and processes by which feed back coming from PRIs and community level institutions can also be dovetailed. This effort at planning should be a comprehensive exercise in utilizing available financial resources, material and manpower, both governmental and non-governmental.

It also needs to be ensured that similar plans are prepared at the level of blocks, i.e. the second tier of Panchayati Raj bodies and are in harmony with the overall framework of the district plan and fully reflect its objectives, strategies and the ethos of its approach, while at the same time leaving sufficient space for the block level plan to identify and operationalise area specific initiatives. This block level plan so prepared has to be taken to the level of Panchayat where a Panchayat level plan has already been prepared. The planning agencies of the district have to ensure that the Panchayat level plan is appropriately dovetailed into and reflected in the block level plan and finally gets harmonized with the district level plan. In the process of interaction between the District level plan and the Block Level Plan and between the block level plan and Panchayat level plan, instruments of

pressure exertion and advocacy have to be used to see that crucial interventions required by lower PRI agencies are incorporated in the district level plan within the constraints of their power and resources.

In this manner, the planning process would become a tool of empowerment, albeit a limited one and grass root level mobilisation referred to earlier would get transformed into an instrument of pressure exertion and advocacy mechanism. Since the District level plan so prepared would have to be approved by the District level planning committee with representatives from Zilla Parishad etc., resistance, if any, on the part of officials to proposals of lower level PRIs requiring resources and support from the district can be neutralized through advocacy and pressure in this forum.

It is expected that over a period of time, horizontal contacts and networking should also develop between PRI bodies in different parts of the State, NGOs, expert agencies to build up combined and intensified pressure on the State Govt. as also political Institutions including major political parties to initiate and effect requisite devolution of powers and authority to different levels of PRIs. This should be accompanied by various mechanisms available with Govt. of India including devolution of financial resources to leverage this struggle. This is a pressure which no political organization engaged in electoral politics can ignore for long because their members will sooner or later have to face the electorate in their constituencies where the politics of devolution would figure as an important issue and people would get educated on who is standing in the way of development benefits reaching them. Devolution of powers & resources to PRIs getting strategically positioned in the political agenda would alone ensure its effectuation in the long run and contribute to these institutions playing an active role in population stabilization.

CHAPTER IX

Suggested Invigouration of PRIs – Role of the National Commission on Population

This report has sought to underline the importance of Panchayati Raj Institutions in achieving the goals of population stabilization as contained in the National Population Policy. It has also brought to the fore the disinclination on the part of policy makers to adequately recognize this role and to embed it in the policy planning documents. This reluctance is not merely evident at the national level but more glaringly so at the State level. What has been strikingly brought out is that even where the relevance and suitability of PRIs for the population stabilization programme have been recognized as an expression of intent, this has been so done in a very general way making reference to their ability to mobilize the people in favour of a small family norm and in identifying unmet needs. But nowhere has this role been conceded or articulated in terms of the comprehensive architecture of powers and jurisdiction which provisions of 73rd Amendment to the Constitution lay down. The basic thrust of national population policy. State population policies and operational strategies concerning them has been to continue positioning the programme as a professionally/ bureaucratically managed effort. The conceptualization of support sought from PRIs in this scheme does not envisage their involvement in planning, resource management, mobilization and control over service providers. This report has therefore suggested a **paradigm shift** in this approach with a view to crafting for Panchayati Raj Institutions a pivotal role in this programme. The change is not merely consistent with their status as democratic institutions entrusted with a specified mandate and jurisdiction but also because of the potential they have in meeting the specific needs of the people. The suggested role would obviously require adequate transfer of

powers, resources and authority to PRIs which most State Govts. have not done. While pressure should be mounted on State Govts. to accomplish this devolution, it has also been highlighted that the capacity of these institutions needs to be built by way of training, confidence generation and democratic articulation, etc., to discharge this role. The contours of this capacity building have also been spelt out. The responsibility to be discharged by PRIs in respect of Population Stabilization is so enormous that they would have to seek help from and utilize various institutions of civil society, such as the NGOs, CBOs, etc. Potential of participatory institutions which have lately emerged on the development landscape, such as self help groups also needs to be harnessed. With this objective, approach to the broad frame of capacity building for the members of these self-help groups has also been laid down.

The programme of Family Welfare in the country has almost entirely neglected the involvement of PRIs in the process of planning. Even where their help is sought, it is by way of carrying out whatever has been determined in terms of national policy. This group has therefore focussed on PRIs, particularly at the grass root level undertaking the exercise of preparing a health and family welfare plan for their area and for this purpose the structure and processes of planning have been indicated. The participation so generated would itself act as an instrument of their empowerment. The working group distinctly feels that the governments, both Centre and States, and at political as well as bureaucratic levels, should remove their basic sense of distrust or lack of faith in the capacity of PRIs to discharge their mandated role and to start entrusting them with specific responsibilities which would generate confidence in them about their competence to handle tasks so assigned and enhance their experience in decision making and execution. It has, however, been recognized that PRIs would need to be helped in capacity building for this purpose and efforts in

this direction should not merely include PRIs but various other participatory formations, i.e. such as NGOs, CBOs, Self Help Groups, etc. The crucial question is who would take up the gigantic task of empowering PRIs and other participatory groups for this purpose? The Approach Paper on the Tenth Five Year Plan clearly envisages a catalytic role for the National Commission on Population in generating a vigorous peoples' movement to support national efforts to achieve the goals set in the National Population Policy-2000. It is in this context that this group has identified specific measures which the National Commission on Population can initiate to trigger the process of empowerment of PRIs. This role has been spelt out in the recommendations which follow. These recommendations have not been discussed in the main body of the report but emerge logically from the analysis presented in various chapters.

1. National Commission on Population should draw up a comprehensive statement of the role of Panchayati Raj Institutions in the programme of medium term and long term population stabilization consistent with their status emerging from the provisions of 73rd Amendment to the constitution and the subsequent law, Panchayats (Extension to Scheduled Areas) Act, 1996. This statement would supplement and enlarge the constricted formulation presented in the National Population Policy-2000, the National Health Policy-2000 and State Population Policies. It should take up advocacy of this reformulated role being reflected with focus and clarity in policy documents related to Health & Population Policies, both at the national and State levels and build up political support for this purpose.

2. Various Ministries of Central Govt. which deal with programmes impinging upon factors contributing to the population stabilization have also brought out their sectoral/ sub-sectoral policies. There are, however, some areas of dissonance between National Population Policy-2002 and those of sectoral/ sub-sectoral policies and, at times,

even among such policies themselves. National Commission on Population should, as a first step, initiate steps to ensure that all these sectoral/ sub-sectoral policies are consistent with one another on issues which touch upon and contribute to the processes of population stabilization in the medium and long term so that commonality of purpose and course of direction is reflected with desired clarity in all these documents.

3. National Commission on Population should identify specific steps needed for transfer of power, resources and authority/responsibility which are very critical for PRIs to discharge their role as per the comprehensive statement outlined at (1) above and prepare strategies and mechanisms for exerting continuing pressure on the State Govts. for effecting such devolution.

4. The medium and long term goals of population stabilization as reflected in National Population Policy-2000 are crucially dependent for their realization on the multi sectoral convergence of performance and inter-sectoral coordination among concerned agencies of Govt. The concerned Agencies of the Central Govt. and State Govts. should therefore clearly spell out component of tasks which PRIs would handle in respect of their programmes [including EAPs] and sectoral/ sub-sectoral Plan strategies which are consistent with the comprehensive statement of their role suggested in (1) above in order that the nodal agency implementing population stabilization programme is in a position to fully utilize their potential for building up a peoples' movement. National Commission on Population should establish mechanisms for exerting pressure in this direction.

5. Central Govt. should launch a 100% funded central scheme for comprehensive capacity building of Panchayati Raj Institutions to empower them to discharge their role consistent with their

constitutional status as envisaged in the comprehensive statement at (1) above.

6. National Commission on Population should take up pilot projects in States for triggering the process of Planning as outlined in this report for achieving, to start with, medium term goals of population stabilization by PRIs. A beginning should be made with village panchayats in this regard. This capability to plan will require lot of efforts and support from diverse agencies and a clear sense of direction besides some financial and intellectual assistance. A core group of experts should be set up at the national level to guide this effort. As the momentum of such planning picks up, a core group should be positioned at the State level also.

7. National Commission on Population should identify panchayats with very adverse indicators in respect of Human Development which constrain the progress of goals set out in the National Population Policy. It should take up action research projects in such panchayats with a view to identifying critical activities/ facilities/ services satisfaction of which would spontaneously lead to a positive and voluntary change in behaviour of the targeted groups. It should provide/ mobilize resources for meeting such needs.

8. National Commission on Population should function as a clearing house for best practices, innovative steps and outstanding performance shown by PRIs in respect of various tasks such as female foeticide/ infanticide, reduction in IMR, MMR, equal treatment of girl child, 100% registration of births, deaths and pregnancies, total coverage of children in School enrolment and their retention, transportation of patients to nearest health facilities, etc. to encourage PRIs elsewhere to emulate them.

9. National Commission on Population should take up specific District/Block level PRIs, at least one in each State, for concretizing ideas, institutional arrangements and processes to implement certain crucial components of operational strategy identified for achieving medium and long term goals of population stabilization, such as convergence of programmes and inter-departmental cooperation, public-private sector partnership, NGO-Panchayat cooperation, mobilization of community organizations and participatory groups, Responsiveness of serviced providers, quality control of Health Care, etc.

10. National Commission on Population should coordinate with the concerned ministries who are engaged in implementing programmes for self help groups and similar other participatory institutions involving women and provide a leadership role to them with financial and other inputs for taking up in a big way the programme training and capacity building for the members of these groups for work relating to population stabilization.

11. National Commission on Population should provide a forum for PRIs, particularly village panchayats, across the country, to share experiences on the strengths, successes and even failures with regard to their efforts to achieve various goals set out in the National Population Policy-2000. This exercise would help them to learn from the experience of one another. It should be appropriately documented so as to function as training literature.

12. National Commission on Population should set up a National Resource Centre for providing various non-monetary inputs, including guidance, assistance of experts, information, relevant literature, etc., to PRIs in various States. It should also start a News Letter exclusively focussing on work of PRIs in relation to population stabilization in the country which could gradually emerge as a forum

for exchange of views, information and experience on the subject.

13. National Commission on Population should get a manual prepared which can comprehensively outline what elected members of Panchayats at various levels can do in respect of wide gamut of powers and responsibilities entrusted to them pertaining to different sectors and how they can pursue their tasks in the context of situation in which they are placed. This manual should be revised from time to time based on experience gathered and should serve as 'Panchayat Geeta' for work relating to population stabilization. It should include in its ambit different dimensions of relationship of PRIs with social, political and economic Institutions horizontally as well as vertically. It should also lay down norms of and formats for monitoring their work.

14. National Commission on Population should work out themes of national campaigns focusing on specific aspects of role of PRIs in relation to medium and long term goals of Population Stabilization which can be carried out during a specified period every year throughout the country as a strategy of peoples' mobilization.

15. National Commission on Population should encourage and promote forums of elected women members of PRIs at Village, Block and District level in which they feel free to discuss their common problems, draw strength from others' experience and develop mechanisms for exerting pressure on issues where they face lack of response or even hostility in the processes/meetings of PRIs/official bodies.

16. Participation being the key to effect improvement in delivery of services and meeting specific needs in relation to the programme, National Commission on Population should identify specific and vulnerable population groups, such as Dalits, Tribals, Minorities, etc.

whose level of participation in PRIs is low on account of varying degree of social constraints which vitally affect their access to health facilities and non-health benefits. NGOs of proven integrity, adequate experience and commitment should be mobilized for helping members of these groups to enhance their participation in PRI fora. Projects specifically in backward areas and in respect of isolated and subdued groups may be taken up for this purpose by the National Commission on Population.

17. In certain areas inhabited by large number of tribal 'communities, such as the North-East, it is not the growth of population which constitutes an issue of concern but the lack of their balanced growth which adversely affects stability of their population. National Commission on Population should, therefore, constitute a small Expert Group to work out a comprehensive strategy for balanced growth of different tribal groups in such areas as a pre-condition for their population stabilization. This should specifically bring out the role of local self governing institutions as well as their own customary organizations in the process of such growth. Besides, some small tribes are facing an alarming decline in population which may lead to their extinction. National Commission on Population should take up on top priority projects in respect of such tribes where the local PRI triggers the process of their focused development for arresting sharply declining numbers, intensive participation of members of the tribe and vigorous mobilization of the larger communities for support.

It needs to be stressed that the above set of recommendations are not an exhaustive list of what National Commission on Population can accomplish to invigourate PRIs but only the first steps. As the momentum of involvement of PRIs picks up, numerous areas would emerge for NCP to intervene to carry the task further and expeditiously realize the goals, medium and long term, set out for population stabilization.

ANNEXURE-I

No.N-11011/25/2000-NCP
Government of India
National Commission on Population

Room No.243, Yojana Bhavan,
Sansad Marg, New Delhi - 1.
Dated 9th October, 2000

ORDER

Subject: Working Group on the Role of Panchayati Raj Institutions and Self-Help Groups in Population Stabilization

1. In pursuance of the decision taken in the first Meeting of the National Commission on Population held on 22nd July, 2000, Working Group on the role of Panchayati Raj Institutions and Self-Help Groups in Population Stabilization is hereby constituted, comprising the following :

i) Shri K.B. Saxena, Principal Adviser, Planning Commission - Chairman

Members :

ii) Shri P.M. Tripathi, President, AVARD
iii) Kalyani State Institute of Rural Development, Calcutta, West Bengal
iv) Kerala Institute of Local Administration
v) State Institute of Rural Development, Pune
vi) Representative of Ministry of Rural Development

vii) Representative of Government of Kerala

viii) Representative of Government of Gujarat

ix) Representative of Government of Madhya Pradesh

x) Representative of Government of West Bengal

xi) Representative of National Commission on Population

xii) Representative of RD Division (Planning Commission) – Convener.

2. **Terms of Reference**

a) To identify gaps and

b) To examine and suggest alternative strategies, interalia recent developments and innovations with due regard to cost effectiveness and optimization of resources, with the objective of contributing to the fulfillment of the objectives of the National Population Policy.

c) To consider any other matter related with or incidental to the above terms of reference.

3. The Advisory Group may co-opt any official or non-official as a special invitee to one or more sittings of the Group.

4. The expenditure on TA/DA of the non-official members, in connection with the meeting of the Advisory Group will be borne by the National Commission on Population, as per rules and regulations of TA/DA applicable to Grade I Officers of Government of India or as otherwise decided by the Vice Chairman, NCP. The expenditure on TA/DA of the

official members, in connection with the meeting of the Advisory Group will be borne by their respective Departments/Ministries.

5. The Advisory Group will submit its final reports to the National Commission on Population within six months from the date of issue of this order.

Sd/-
(Krishna Singh)
Member Secretary,
National Commission on Population

To:

1. All Members of the National Commission on Population
2. All Members of the Working Group

Copy to:

1. JS, Prime Minister's Office
2. PS to Deputy Chairman (Planning Commission)
3. PS to Member Secretary (National Commission on Population)
4. PS to Joint Secretary (National Commission on Population)

(L to R) Dr. Rohini Nayyar, Adviser (RD), Planning Commission and
Dr. Nagesh Singh, Director (RD), Planning Commission.

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